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ORIGINAL LECTURES.

COCAINE IN HAY FEVER.

Lecture Delivered at the Chicago Medical College,

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Gentlemen:—America has probably a hundred thousand sufferers from hay fever, a number about four times that of the standing army. Any information relative to this subject, especially if it offer a ray of hope of relief or cure, is eagerly sought by this vast army of unfortunates. After several years' study of this disease I shall endeavor to present a correct account of the present status of our knowledge concerning its pathology and treatment. The several names which this affection bears are unfortunate ones, inasmuch as they do not adequately express its pathology, symptoms, or causes. The pollen of grasses, weeds and flowers, and the heat of summer, are but a few of the large number of exciting and predisposing causes.

If I were to invent a name for it, both simple and expressive of the nature of the disease, I should call it nervous catarrh. I do not know that it has ever been called by that name, but it has not been generally conceded, until recently, that the malady was essentially a nervous one. Perhaps a better name than the one I propose could be found, if one should insist that technical terms only, such as neurasthenia, should be admitted into medical nomenclature. But nervous catarrh is an expression which would indicate both the true nature of the disease and the prominent symptoms which characterize it. The term hay fever does neither; for while hay, in common with many other kinds of pollen, dust, fumes, gases, and so forth, may excite attacks, many suffer from paroxysms into which neither hay nor fever enter as a factor, either causative or symptomatic.

In my first efforts to gather information on this subject I discovered that hay fever was considered a conundrum by a part of the profession and a myth by the remainder. By the paucity of the literature of the subject it was evident that medical authors did not mean to write most concerning that of which they knew the least. From the time of Bostock's discovery of the disease in 1819 to the year 1876, the nature of this affection seemed to be but ill-understood. In the light of the accumulated knowledge of the past ten years, however, it seems to be well established that its proper classification is among the neuroses. During my first experience with this intensely distressing disease, I followed Helmholtz's suggestion to destroy the vibrio-like bodies which inhabited the nasal secretion, and which he supposed caused the attacks, by the inhalation of a nebulized solution of quinine. This gave relief. I next tried the effects of administering the same drug internally, and was rewarded by even more satisfactory results. Certainly the infusoria in the nasal secretion were not destroyed by the internal use of half a dozen grains of quinine a day.

The susceptibility must exist in the nervous centres as well as in the end organs of the nerves. Otherwise there is left no rational explanation of the fact that heretofore internal medication by nerve tonics and sedatives have proved more serviceable than local treatment. This conclusion seemed to be verified by the fact that it had been demonstrated that a severe catarrhal condition of the nasal mucous membrane followed ablation of the spheno-palatine ganglion, which shows the intimate relation sustained between that sympathetic nervous centre and the nervous supply of the mucous membrane involved. Branches from this ganglion are distributed to the lining membrane of the nose, soft palate, and the end of the Eustachian tube. The motor root of this ganglion is derived from the facial, and the auricular branch of the pneumogastric nerve unites with the facial. Thus is established an intimate connection between the nervous supply of the nose, throat, Eustachian tube, larynx, and bronchial tubes; and the explanation of the occurrence of aural and asthmatic symptoms as the result of nasal irritation is made clear. It becomes evident, then, if we study the disease from anatomical, physiological and clinical standpoints combined, that there is but one theory which satisfactorily reconciles all the known facts. According to that theory three conditions are requisite to the existence of a paroxysm of hay fever: First, abnormally sensitive nerve centres; secondly, a hyperæsthetic condition of the peripheral extremities of the nerves; and thirdly, the presence of one of a vast number of irritants.

The truth of the first proposition is evident from the fact that it is the only one which satisfactorily explains why but few individuals are affected, out of a large community, all the members of which are alike exposed to the same irritating ingredients of the atmosphere; why ablation of the spheno-pala-

tine ganglion causes a severe catarrhal condition of the nasal mucous membrane; why nervous depression, or exhaustion (neurasthenia) predisposes to hay fever attacks; why tonics and sedatives to the central nervous system alleviate, abort, or prevent attacks; why sudden mental excitement may prevent an impending paroxysm, or abbreviate one after its onset; why the disease generally attacks one at precisely the same time, lasts the same length of time, and disappears at the same time on each recurring season; why the class of people who suffer from this affection are the nervous, brain-working type, instead of the phlegmatic, slow-going kind, who may be more exposed to the pollen of the field or the dust of the work-shop and street, but whose minds are strangers to the nervous stimulation and mental tension of the professional man; why the paroxysm is as sudden in its invasion as asthma, striking one at any moment of day or night, awaking one from sound slumber, or taking one unawares during the pleasant engagements of the day, and leaving one as quickly and mysteriously as it came.

Moreover, some functional nervous diseases are transmutable, one into another. I have witnessed cerebral hyperæmia decline and disappear as hay fever superseded it, and after several years' duration the hay fever has in turn been displaced by asthma, as spasmodic and characteristic in its nature as the hay fever itself. Simple asthma may not only supplant, but may complicate it, constituting hay asthma proper.

An error which has been as popular as the Helmholtz theory is the supposition that this affection is necessarily limited to any particular season. The enervating effect of extreme heat in summer is an important predisposing cause, as affecting the nerve centres; but in the colder seasons the depressing effect of the heated atmosphere of overcrowded, ill-ventilated rooms, and any causes which render the nerve centres more sensitive, and consequently less able to resist impressions from external irritants, are also provocatives, and bear the same causal relation to hay fever as does the heat of summer.

In stating the second condition, it will be noticed that I have not limited the hyperæsthetic condition of the peripheral nerve fibres to those which terminate in mucous membrane alone. To demonstrate the correctness of my implied hypothesis it is necessary only to cite those cases in which paroxysms are produced by the rays of the sun, or other bright light, irritating the retina, or an attack provoked by irritating the scalp with a comb, or shaving the upper lip, or a draught of cold air chilling the back of the neck, or hands, or feet. A reciprocal relation exists between the capillary circulation of the skin and that of the internal organs, but more especially affecting the mucous membrane lining the air passages. Let the surface of a hay fever patient become chilled, the skin anæmic. the perspiration checked, and immediately there follow a corresponding hyperæmia of the mucous membrane of the respiratory passages, an increased activity of the muciparous follicles, exquisite tickling and painful itching in the nose and pharynx, succeeded by violent sneezing, profuse discharge of nasal mucus, suffused and tear-bedimmed eyes, photophobia, a rush of blood to the head and face, severe headache, complete occlusion of the nostrils, nervous exhaustion, and such a desperate shaking up of the whole being as is comparable to a wrecked vessel in a terrific storm. But in this violent agitation of the body I have discerned a blessing in disguise, for it restores the balance of circulation to the skin, the temperature rises, the sudoriferous glands resume their activity, and the skin is again bathed in perspiration. At this juncture the vicarious suffering of the respiratory surface is relieved, and the normal equipoise of functional activity ensues. In one who suffers from the asthmatic form of hay fever, to the symptoms already enumerated should be added the characteristic symptoms of asthma proper. These alone make one's lot hard enough, but when added to the so-called aristocratic disease, present a highly colored picture of the refinement of torture.

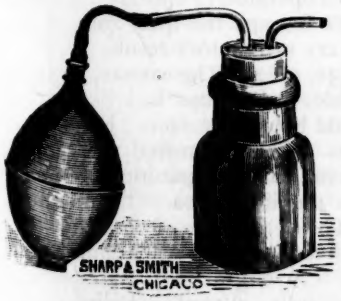
The truth of the third proposition is self-evident, and the number of irritants, such as pollen, dust, matches, and so forth, which directly excite attacks, would be too extended to enumerate.

The treatment of hay fever is preventive and palliative. No curative treatment has heretofore been discovered. The preventive treatment has compelled sufferers to become fugitives from the air breathed by common mortals, and to seek mid-ocean or the tops of mountains in their seasons of distress. The most important palliative remedies are quinine, chloral, and morphine internally, and quinine, chloroform, and carbolic acid by inhalation. In my experience quinine has given more relief than any other remedy; but there is great danger of impairing the hearing by the use of large and frequently repeated doses, for it causes congestion of the middle ear, and probably of the labyrinth. The ideal curative treatment would be that kind which addressed itself to the seat of the disease, which resides in the central nervous system. Narcotics are the only known remedies which render it entirely oblivious to the presence of the many harassing irritants which insist on being recognized, and which appear to have the same relation to the nervous centres that persistent office-seekers do to the President. But since it might be objectionable to keep patients in a comatose condition during the weeks or months of their hay fever seasons, the only medicinal treatment left to our choice is that which affects the peripheral termini of the nerves.

Cocaine has grown, mushroom-like, into a wonderful popularity. Let us hope that its usefulness in hay fever may not prove as ephemeral as its growth. Unfortunately, those drugs which are most influential for good are also most disastrous in their effects when their use is not directed and limited by skill. Cocaine is no exception to this rule, and the sooner the knowledge of its harmful properties is widely disseminated the better it will be for all who may have occasion, or invent an excuse, for its use. Serious results have attended its use in the nasal cavities. Being a powerful local anæsthetic, its advent has been hailed with enthusiasm by all that large class

of sufferers whose sensitive mucous membranes make them miserable. Many who used cocaine during their attacks last summer believe themselves to be cured. But let us look facts fairly in the face and state candidly truths which we cannot evade if we would. Can we expect the cure of a disease, the perpetuity of which seems coextensive with the subject's life, by a remedy the effects of which are transitory? The rapidity of action and the intensity of analgesic power of cocaine are indeed remarkable, but its benumbing effect lasts but one or two hours, or less. In order to extend its influence over a considerable number of consecutive hours or days, it is necessary to repeat the applications of a four per cent. solution as often as once in an hour or two, and even at briefer intervals. The consequence is an absorption of so large a quantity of the drug as will produce its physiological and even toxical effects. This, together with the fact of its evanescent character, would seem to render it highly improbable that cocaine will ever prove to be a cure for hay fever. As a palliative it acts like magic in some cases. At first I employed a four per cent. solution of the hydrochlorate, applying it to the sensitive points by means of surgeon's cotton twisted on a holder. That failed to relieve, and excited paroxysms of sneezing. This result was due to the fact that too little of the solution was conveyed to the parts. Afterwards I used the same solution with a camel's-hair brush, taking pains that the parts were first thoroughly cleared of mucus, and immediate relief was obtained. A two per cent. solution has often proved effective.

I have more recently used a six per cent. powder of cocaine and sugar of milk, in an insufflator which I have devised for hay fever patients, for self-treatment. The instrument is small enough to carry readily in the vest pocket, and can be used easily the instant an attack seems imminent. The insufflator consists of a two-drachm vial with a stopper through which pass two vertical tubes. These do not extend below the under surface of the stopper. Above it they are bent in opposite directions. To one of these bent extremities is attached a rubber tube, to the free end of which the mouth is applied. A slight puff of the breath is sufficient to send the powder through the opposite tube into the nasal cavities, when the instrument is in position. The tubes should be made of vulcanite, and the vial should not be more than two-thirds full. The instrument is constructed after the plan of my larger office insufflator, except that in the latter a rubber bulb supplies the place of the mouth. This method of applying cocaine in powder is simple, effective and easily practiced even in public assemblages, without making one feel offensively conspicuous. I may dismiss this part of the subject by remarking that many cases have been wonderfully relieved by this treatment. In compliance with the request preferred by some of you, I shall speak of its general as well as its topical effects.



Office Insufflator.

Pocket Insufflator.

When applied to the mucous membrane of the nose, a four per cent. solution produces, in a few seconds, a sense of numbness which grows more marked as the applications are repeated. If they are renewed at intervals of five minutes for fifteen or twenty minutes, at the expiration of that time the mucous tissue may be cut or cauterized without any well defined sensations, unless the instruments enter very deeply into the sub-mucous tissue. If sensations and pain return soon after an operation it may be obliterated again by a fresh application. Very soon after cocaine has been applied, the membrane looks pale and turns almost white, so anæmic does it become. It retracts in a marked manner even if it were swelled before the application. But I have repeatedly observed a still further effect which I have not seen mentioned in any account of the action of cocaine. Although its primary action produces anæsthesia and anæmia of the membrane, there occur secondary effects which will materially impair or destroy its usefulness in some cases. These secondary effects are great swelling and hyperæsthesia of the parts treated, and these symptoms are even more prominent than they were before the drug was applied. This unhappy result I observed in the treatment of a severe form of hay fever, and in consequence of the augmentation of all the symptoms after the effects of the cocaine wore off, I was compelled to abandon that treatment. Several cases have come to my knowledge in which this action of cocaine has ensued. It seems to act upon the vaso-motor nerves, independently of the central nervous system. The blood-vessels are at first constricted, then dilated, and generally resume their normal calibre. In the exceptions which I have mentioned the dilatation remained for hours, and in one case persisted for a number of days, accompanied with varying degrees of hyperæsthesia. The latter symptom was very acute for several hours succeeding the anæsthetic effects, but gradually diminished until the membrane became no more sensitive than it was before the treatment. The secondary swelling closed the nostrils so completely that no air could be forced through them. In sleep it was necessary to breathe through the mouth, which occasioned extreme dryness of the throat. The breath had to be held while eating, and with every act of swallowing the air was forced into the Eustachian tubes, and even particles of food seemed to take the same course. No one can realize the importance of open nasal flues until he attempts to eat, sleep or talk with them closed. Cocaine would relieve this secondary tumefaction temporarily, but it would return after each application. Fortunately

there seem to be but few who are so peculiarly affected by this remedy. I have employed it in many cases of various diseases in which I have observed no disagreeable consequences, and shall be glad to relate the gratifying results obtained at another time.

The physiological and toxic effects are somewhat similar to those of theine and caffeine. Cocaine is a powerful poison affecting the nervous, respiratory, circulatory and vaso-motor systems. In small doses it is a prompt and decided cerebral and cardiac stimulant without inducing coma. The pulse and respirations are accelerated, the intellectual processes livickened and exhilarated, and the mental vision deeghted with agreeable hallucinations. Diplopia, aonstipation, muscular tremors, vertigo and nausea qre a series of symptoms attending larger doses. Still larger doses produce contracted pupil, complete paralysis of sensibility, tetanic spasms, and death. It does not produce muscular paralysis, but does paralyze the entire posterior columns of the spinal cord, and the entire system of peripheral sensory nerves. Accounts of cocaine-poisoning disagree as to the condition of the pupils. In some cases they are said to have been widely dilated, in others contracted, as in opium-poisoning. Cocaine placed in the eye dilates the pupil widely. However, cocaine-poisoning simulates opium-poisoning so closely that the former has been mistaken for the latter and treated for opium-poisoning, with recovery.

The new surgical treatment of hay fever, which consists in cauterizing the sensitive areas, is too recent to have afforded permanent results. Not wishing to prejudice against the operation those to whom it might prove beneficial, I willingly part company with this phase of the subject. But I cannot do so with fidelity to the profession and to this class of patients without warning them of possible consequences. This treatment may precipitate paroxysms of veritable asthma. In fact, two applications of the galvano-cautery, under cocaine anæsthesia, have superinduced true asthma without curing the hay fever.

He who finds a cure for this disease need take no thought for the morrow, for that great army of sufferers would cast their golden treasures at his feet, and profession and people alike would erect to his memory a monument more enduring than bronze and more lasting than stone.

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ORIGINAL ARTICLES.

EXPERIENCES WITH THE AXIS-TRACTION FORCEPS.

BY T. FELSENREICH, M.D.,
DOCENT OF MIDWIFERY AND GYNÆCOLOGY IN VIENNA.

I consider it very fortunate that the years of my service as assistant just coincide with the time in which great progress was made not only in gynecology, but also in midwifery. The thorough use of antisepsis, the entire reform of the *sectio Cæsarea* by the method of Porro, the modification of the forceps for the higher-lying head, suggested by Tarnier, the prophylaxis against *blennorrhœa neonatorum*, took place in the short period of six years, during which I was clinical assistant. By this circumstance I had the opportunity to study these points in an exact manner, alone and with colleagues, as it is not possible to do in private practice.

I operated originally with one of the first patterns of Tarnier's forceps. The result was then bad both for mother and child. But we had chosen severe cases, very wrongly, for this is the way to discredit even a good and useful method in the first stage of its development. But even these experiments with Tarnier's[1] complicated forceps were sufficient to prove thoroughly the correctness of his principles. For Vienna it was principally important that Prof. Gustav Braun should come to the same opinion and decide to follow the further modifications of this forceps and to try their value. Without G. Braun we probably should not know about the axis-traction forceps practically more than that which Kucher imparted to us. The adversaries of Tarnier and his principles were to be found among the older and younger obstetricians, Many of them condemned his forceps, and condemn it still, partly without knowing what the matter in question is, though French, English and German physicians have tried to cultivate Tarnier's ideas, and the patterns have become more and more simple and serviceable. The same fate befell the simple prophylaxis against *blennorrhœa neonatorum*. An assistant who had been during several years in service, declared five years ago that he knew a clinic where no *blennorrhœa neonatorum* could be found, although the prophylaxis had not been introduced at that time. Only the method of Porro found universal approval here.

In spite of these adversaries, A. R. Simpson's axis-traction forceps found here in Vienna a place where they were impartially tried. When I first saw the forceps the delicateness of the blades and the spring-like consistence of the material struck me. A pair of forceps, devised especially for a head which is out of proportion or high-lying, ought to have at least the same firmness and the same size as the common forceps. The otherwise very simple construction of the axis-traction forceps, and the employment of the form of our "Schulzange" (by J. Y. Simpson) in the construction of it, induced Prof. C. Braun to allow experiments with it. I operated (February 24, 1882) with A. R. Simpson's forceps the first time in his presence, and with very satisfactory result.

Case.—Prot. No. 536, 1882. The woman, 33 years old, III-para. Outside, the forceps had been tried twice, without the child being extracted. Flat pelvis, *conjugata vera* 8 cm. The exhausted uterus was sunken to the right side. The tympanitic percussion sound reached up to the linea alba. Temperature and pulse normal. The heart-beats of the child accelerated, the head fixed, its greatest circumference above the *conjugata*. A large *caput succedaneum*. The *os uteri* nearly fully dilated. Disinfection, narcosis. Alexander Simpson's axis-traction forceps. Easy operation with few tractions. Moderate atony

[1] The recent patterns of Tarnier must be simple and good, as Dasseige has altered decidedly his opinion about this instrument.

of the uterus and hæmorrhage, caused by the necrosis. Disinfection; massage; ergot.

Child living; weight 3500 grm. Patient was discharged as usual on the eleventh day. The mother got pleuro-pneumonia without connection with the puerperium, and left the hospital healthy on the 17th of March.

Dr. Pritze and I operated with this instrument in six other cases. Four were small pelvis cases; head in all cases high up and fixed. In the two cases with normal pelves the children were large, the one (4270 grm.) profoundly asphyxiated, the reanimation was not successful; the other (4400 grm.) was born living. In two cases the extraction with A. Simpson's forceps was vainly attempted, so that craniotomy was done. In one case (normal pelvis, child 4270 grm.) the head was drawn with the axis-traction forceps down to the perineum. At the exit of the head the instrument was about to slip off, so that the last part of the extraction was performed with C. Braun's forceps (J. Y. Simpson's forceps, obliterated fenestræ and handles, covered with hard rubber). In another case the button on the right traction-rod was broken during the tractions, so that the operation was finished with the common forceps. Three children living, one asphyxiated, two still-born (craniotomy). Three puerperia passed normally. Three women became ill with a light encolpitis, but were healthy when discharged.

These trials with A. Simpson's forceps and the complaints about their faults became apparently known in Edinburgh, so that someone had the extraordinary kindness to send me from there a much more solid instrument, for which kindness I now find the opportunity to express publicly my thanks.

The sixteen cases mentioned by A. R. Simpson in his paper on the axis-traction forceps include only two cases of narrow pelvis. Therefore it was not possible to try sufficiently the instrument in cases for which it had been devised, viz.: on the high-lying head. With a larger number of cases of narrow pelvis A. R. Simpson undoubtedly would have got the opinion that the forceps only sufficed for the lighter cases, but that it cannot cause the head to accommodate itself to the disproportion of the pelvis. He should have combined the axis-traction apparatus with the forceps of J. Y. Simpson, as firmly constructed as the Viennese pattern ("Schulzange"). In this way he would have got a well constructed and reliable instrument.

The disadvantage of the fixation screw is usually exaggerated. Drawing the screw too close naturally causes damage, as well as the violent compression of the gaping handles of the common forceps, if they are adjusted to the high-lying head. It is not necessary to mention that one must loosen the screw and the handles of the forceps during the pauses between the tractions, just as it is the rule in using any other forceps. The head recovers from the compression under otherwise favorable circumstances. The screw is only to effect the fixation of the forceps and not the compression of the head. It is therefore constantly controlled by the exploring hand, and is at first only slightly drawn.

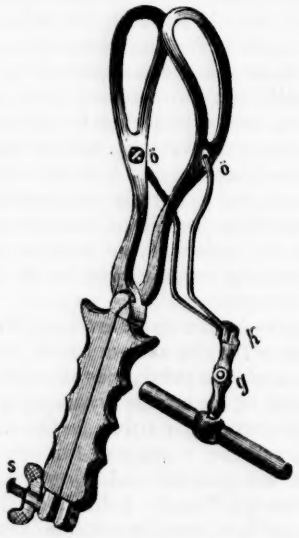
For the extraction with the axis-traction forceps only one hand is required. If the power of one hand does not suffice for the traction, this shows, according to my experience, that there is such a disproportion that the operation with forceps cannot result favorably to mother and child. The successful traction with only one hand is the best proof that much power is spared in using the axis-traction forceps in consequence of the proper direction of the traction. This is also the best affirmation and proof of the correctness of Tarnier's ideas. Even the most skilful operator, who best knows the pelvis, cannot estimate all factors which are called in question and often incessantly change (the narrowness and shape of the pelvis, the size, hardness, position and accommodation of the head). Therefore he cannot constantly draw his instrument in the axis of the pelvis. If we wish to follow the latter surely and avoid every injurious direction of the traction, we must resort to a pair of forceps which find, so to speak, the shortest way through the pelvis by themselves, and which leave to the head the greatest liberty of movement during the tractions. By this circumstance the head attains in its progress through the pelvis a certain independence of the direction of the traction. This is attained in a different degree by the axis-traction forceps, the name of which appropriately was changed by Breus[2] to "pelvic-entrance forceps."

The usefulness of the axis-traction forceps of Alexander Simpson for the extraction of the head fixed at the entrance of the pelvis was proved to me after the first trials to be sure, only by using a firmer and more safely constructed pattern. The traction contrivance was, on the contrary, for the pelvic-exit nothing but a disagreeable addition. Like Sänger with the forceps of Busch, I had the intention of transforming our firm, excellent "Schulzange" of J. Y. Simpson in such a manner that they would not be changed in their approved form for the pelvic-exit, but that they could be changed into an axis-traction forceps after A. Simpson's pattern by affixing the traction-rods to them. In this manner they could afford also the advantages of the latter forceps.

Executing this intention I came, when I interrupted my clinical activity, only to the first pattern, after which several specimens were constructed by Leiter in Vienna. The adjoined diagram, taken from Leiter's catalogue, releases me from giving an exact description. The size and the proportion of the parts are perfectly equal to those of the forceps of J. Y. Simpson. It is important that the traction-rods should only be made from one piece of steel. They have nowhere a soldering. If this be not the case, they would not accomplish their purpose, and would easily break at the operation; as it happened to me with the upper button of one traction-rod. The fixation of the traction-rod on the blade of the forceps by the simple metal button is on this first pattern still too loose and too unsteady. Also the curvature of the traction-rods is unnecessarily strong and could be flatter as in Sänger's forceps. The joint of the

[2] C. Breus. Die Beckeneingangzangen, Wien: Toeplitz u. Deuticke, 1885.

traction-rods consists of two metal grooves, in which the two button-shaped ends of the traction-rods are attached. This really very simple manner of forming the traction-rods I should like to have changed in another pattern, perhaps by the contrivance of Tarnier, as it is brought in use again by Dr. Neale. Certainly this gives more firmness to the traction apparatus. Also the endplate of Sänger's[3] instrument could perhaps be used, if one would correspondingly change the ends of the traction-rods. In short, it would be necessary to change much before one could advise the forceps for common use. Therefore I omitted a description and added to the diagram in Leiter's catalogue a direction for use which may follow here literally in order to make the report complete.



FORCEPS AFTER SIMPSON, MODIFIED BY FELSENREICH.

The axis-traction forceps were constructed with the intention to give to every skilful obstetrician the possibility of using such an instrument on the high-lying head, without requiring another forceps for the common cases. The forceps consist of the common forceps of J. Y. Simpson, a compression-apparatus *s*, two traction-rods, which can be attached at *ö*, and a transverse handle grasping the traction-rods at *k*, which is movable to the sides by a joint at *g*.

DIRECTIONS FOR USE.

1. One may use the forceps without compression and without traction-rods in the manner till now used for the head (face or vertex), being on the perineum or in the middle of the pelvis.

2. If the head is high up, each blade is mounted with the proper traction-rods, this is taken with the handle of the blade, and the blade is then applied. After having applied the right blade one pushes its traction-rod over the left handle. Then the compressorium and the transverse handle is attached, with which one makes the test-traction and the tractions themselves. One follows in the direction of the tractions the movement of the solid handles and adheres closely to them.

3. One must avoid a too strong compression of the head and must open the screw between each traction.

4. This instrument does not extend the indication for the use of the forceps on the high-lying head. One must be warned of using more power. Generally the pull of one hand suffices.

I operated with this instrument, which is, as I mentioned before, in many respects imperfect, in five cases; four times in cases of narrow pelves. The shortest *conjugata vera* was 8 cm. Three children were born living, two asphyxiated. On child was reanimated and could be dismissed healthy on the tenth day. The other died the day of the extraction in spite of reiterated trials of reanimation. The weight of the children was 3350–3750 gram. The puerperium of the five mothers (one primipara and four multiparæ) was in every way normal. Four mothers were dismissed at the same time with their children.

The number of the cases is small, but the results for mother and child very good. The circumstance that the children were living shows certainly that the compression-screw, if correctly nsed, is not dangerous. The name compression-screw is unluckily chosen; better is fixation-screw. The use of the first name itself would cause a prejudice. In spite of these favorable results for mother and child I cannot advise the instrument for common use. Only a skilful and cautious operator will find the right measure in every respect, and the instrument requires a constant control. The construction of the pelvic entrance forceps by Breus is simpler corresponding to its special purpose. One can better advise this forceps for a common application. Also, with this forceps, as with all similar instruments, the operator must moderate his powers very much. The forceps is not constructed to overcome every obstruction caused by disproportion. One can hurt mother and child with too much force applied in the right direction as in other cases, only perhaps in another place. I have seen infraction of the parietal os on the head of the child after the use of a pelvic-entrance forceps, because the forceps trial had been extended too far. Every good thing turns, if used immoderately, to bad.

The difference between the modifications of Felsenreich and Neale are not great, and certainly not essential. By my communication, which would be otherwise useless, Dr. Neale learns the advantages and faults of his and my instrument, so that he perhaps will be able to avoid the latter and to devise a pair of forceps which are proper both for the pelvic-entrance and the pelvic-exit. If he succeeds, then he has certainly fulfilled a want of the practical physician, for our instrumentarium scarcely allows an increase by a separate pelvic-entrance forceps. I would congratulate him with pleasure, and would be very glad that his sojourn at the University of Vienna should bear such beautiful fruit. Dr. Neale's industry and zeal for gynecology will always remain a very pleasant memory.

Vienna, December 6, 1885.

[3] Verhandlungen der gynecol. Section der 55. Versammlung deutscher Naturforscher und Aerzte in Eisenach.

INTUBATION OF THE GLOTTIS FOR MEMBRANOUS LARYNGITIS.

BY E. FLETCHER INGALS, M.D.,

PROFESSOR OF LARYNGOLOGY IN RUSH MEDICAL COLLEGE, AND PROFESSOR OF DISEASES OF THE THROAT AND CHEST IN THE WOMAN'S MEDICAL COLLEGE, CHICAGO.

Considerable interest has recently been excited in the profession by reports of several cases in which tubage or intubation of the glottis through the natural passages has been practiced as a substitute for tracheotomy. We are indebted to the ingenuity and persistence of Dr. Joseph O'Dwyer, of New York, for the instruments with which this operation is performed, and for the first practical use of this novel procedure, though several before him have experimented in the same direction. We are further indebted to Dr. F. E. Waxham, of this city, for his enthusiasm in trying the new method, which has brought it fairly before the profession. With unusual modesty Dr. O'Dwyer seems to have experimented a long time before any outside of his immediate circle of acquaintances knew of his efforts; it being his desire to perfect the instrument before publishing his results.

In April, 1885, Dr. Waxham procured a set of Dr. O'Dwyer's instruments, and he was so encouraged by his success that he has used them to the exclusion of tracheotomy until he has treated a number of cases by this method, eleven of which he has published. At the time of his last writing two cases had recovered and two others were apparently convalescent. His experiments demonstrate that there is a field of usefulness for the new operation, especially among very young children.

Recently Sharp & Smith, of this city, obtained for me a set of Dr. O'Dwyer's improved instruments, which I have used in two cases. The first of these was a child about two years of age, to whom I was called by Dr. A. M. Stout. The child had been suffering from diphtheria for several days, and when I saw it had passed into the third stage of diphtheritic laryngitis. There was lividity, constant dyspnœa, stridor and inspiratory retraction of the softer portions of the chest walls. As we could get no assistance, Dr. Stout held the child while I introduced the tube, which was done with little difficulty. After five or ten minutes breathing became easy, the patient seemed perfectly comfortable, and it soon fell into a natural sleep. The relief here was as great as would have been obtained by tracheotomy, and the subsequent course of the case was the same, in all probability, as it would have been if the trachea had been opened. Breathing continued easy for about thirty-six hours, then there was a gradual failure of the respiratory function. The child died easily about forty hours after the tube had been introduced. There had been no choking in the meantime. The tube was removed, after death, and found perfectly free.

The second case was a strong boy about five and a half years of age. The parents had, two or three years previously, lost one child from membranous croup, and therefore were anxious to do all they could to save this one. The boy had been taken with croupy symptoms a day or two before I saw him. I found the eyes bright, the skin bathed in perspiration, cheeks, lips, and nails becoming livid, and recession of chest walls. The pulmonary signs were normal, and there was no evidence of diphtheria. Had the environments been good, I should have expected to save this patient by tracheotomy, but owing to the poor surroundings, and the certainty of poor nursing, we decided in favor of the new method. I accordingly introduced a tube, 2¼ inches long, such as is recommended by Dr. O'Dwyer for children of this age. The breathing was immediately relieved, and after about ten minutes became easy, though, owing to the small calibre of the tube, it was not so free as in health. At the time it seemed to me about seventy-five per cent. better than before the tube was introduced. Dr. Todd reports that for about twenty hours the patient was cheerful and breathing comparatively easy, but later the breathing became more rapid, numerous mucous râles were heard over the upper part of the chest, the pulse, which had been nearly normal, became feebler and more frequent, and matters grew steadily worse until the child died about thirty-nine hours after the tube had been introduced. Dr. Todd says, "I think that life was somewhat prolonged and the suffering considerably mitigated by the intubation." In the first of these cases the result was as good as I could have expected, but in the second I believe that a proper opening in the trachea would have greatly improved the child's chances if it could have been properly cared for after the operation.

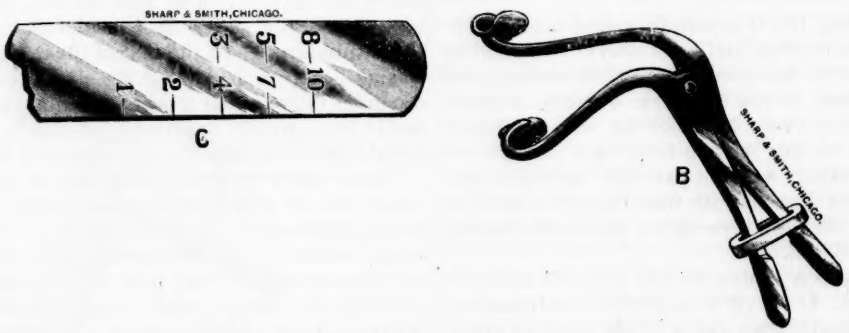
I have seen reports of only five of Dr. O'Dwyer's cases, two of which, aged respectively 3¼ and 3½ years, recovered. It is too early to judge of the actual merits of this operation by the results in the few cases published, but they clearly demonstrate its practicability and no small degree of usefulness. I believe that for children under 3½ years of age it is preferable in nearly all cases to tracheotomy, but for older children the tubes thus far furnished are not large enough to admit a sufficient quantity of air, and therefore in severe cases life may often be lost when a timely tracheotomy would have been successful; but notwithstanding these objections, the ready consent to this operation where tracheotomy would not be allowed, the ease with which the tubes may be introduced, and the freedom from danger in the operation itself, render this procedure, as it seems to me, a most important advance in the treatment of diphtheritic laryngitis and membranous croup. Often parents would not consent to having the child "cut," as they express it, who would at once assent to this method. Often there are circumstances which induce or compel the physician to defer tracheotomy until it is too late, in which cases, if this method were employed, several hours might be gained, and then, if necessary, tracheotomy might be performed.

The ease with which the operation may be done will prompt its early adoption, and thus carbonic acid poisoning may often be avoided, and doubtless the extension of the disease thereby materially lessened. Again, many who might well hesitate to attempt tracheotomy need not hesitate to introduce one of these tubes; for with a knowledge of anatomy which all physicians are supposed to possess, and with

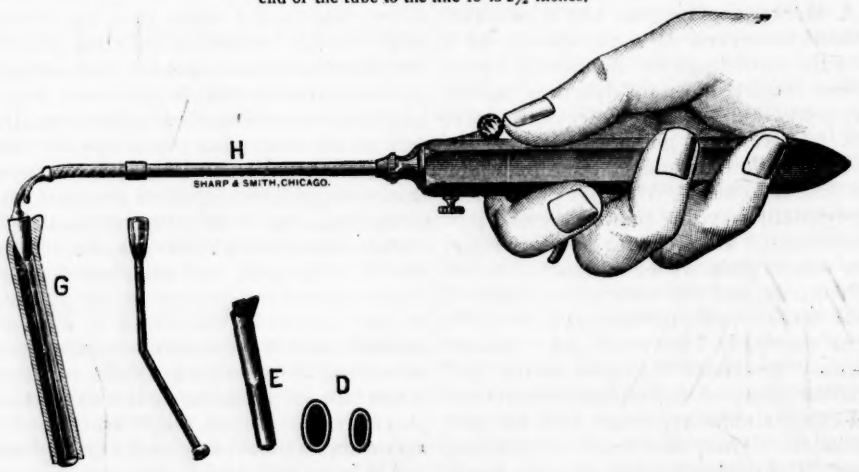
reasonable care not to exercise too much force and to use due dispatch, no possible harm can come. What though the tube were introduced several times into the œsophagus, it could be easily withdrawn by the attached thread, and it might finally be lodged in its proper place. There appears to be very little danger of the tube slipping through the glottis, and even if it should it is so long (reaching, as it does, to within half an inch of the bifurcation of the trachea), that there would be no special danger from it, and if it could not be removed *per os* it might readily be extracted after tracheotomy.

not open quite wide enough for children over three or four years of age. There are five laryngeal tubes, which range in length from 1¾ to 2½ inches. The calibre of the largest and smallest of these is shown in the cut, and is seen to be only ⅛ × ¼ of an inch in the largest, and not more than half this capacity in the smallest. Each tube has at its upper extremity an eye for the silk thread used when it is being introduced. There are jointed obturators which fit each of these tubes and hold them while being introduced. They are jointed in order that they may be more readily withdrawn when the tube is in the

A.—Extractor. Half size.



B—Gag. Half size. *C*—Gauge, actual size, excepting that the end is shown broken off. The distance from the end of the tube to the line 10 is 2½ inches.



E, F, G and H, half size.

H—Applicator screwed into the obturator, which is in the tube *G*, ready for insertion. The artist, however, has made a mistake and shown the tube *G* with its back edge in front. *E*—Smallest tube, bulging on the sides at the middle. *F*—Obturator. *D*—Actual size of the opening in the largest and smallest tubes.

Dr. O'Dwyer's set of instruments contains a gag, five laryngeal tubes, an applicator, extractor, and a gauge. The gag for keeping the mouth open is all that is needed for very young children, but it does

larynx. The rounded lower extremity of the obturator is of a size and shape to perfectly close the opening in the tube, and prevent injury to the soft tissues during its introduction. Its upper extremity has a

small hole, into which the applicator is screwed when the instrument is ready for use. The applicator is shown in the cut with the obturator partially screwed on. The stem of this instrument is covered by a sliding tube which, when the laryngeal tube has been inserted, may be crowded forward by the thumb-piece to release the obturator so that it may be withdrawn, and leave the tube in position. The instrument for removing the tube is constructed on the principle of a dilator. In using it the closed blades are passed into the end of the tube; the lever is then pressed down by the forefinger, when the opening blades impinge so firmly against the sides of the tube that it is held securely. This has been found more convenient than the forceps which were first employed, and it has the additional advantage that it cannot injure the soft tissues. The gauge is designed to determine the size of the tube to be used in a child of any given age.

In performing the operation the child should be wrapped in a sheet or shawl, which will pinion the arms, and then held upright in the nurse's lap. An assistant holds the child's head. The gag is then introduced between the jaws, far back on the left side of the mouth, and opened as wide as need be, but not with great force. The physician, sitting in front of the patient, passes his left index finger over the base of the tongue and down behind the epiglottis, and with it guides the end of the tube into the glottis.

Dr. O'Dwyer recommends that the handle of the applicator be held near the child's sternum until the end of the tube has reached the pharyngeal wall; but I think it will usually be found more convenient to hold it to one side. The end of the tube having reached the pharyngeal wall, it is directed downwards and forwards along the index finger into the larynx. This will not be found difficult, but the infant's epiglottis is so small and flaccid that the operator may not be able always to recognize it, though he will have no difficulty in detecting the larynx as a whole, which, except that it is slightly irregular, feels much like the end of one's little finger. The operator should not expect to detect the opening of the glottis, but must be guided by his anatomical knowledge to pass the tube into the centre of the larynx. Unless he is careful to carry the handle of his instrument high and thus bring the tube as far forward towards the base of the tongue as possible, the tube will be passed into the œsophagus. While it is desirable to accomplish this portion of the operation as quickly as possible, it should not be done with too great haste. Ten or twenty seconds, which is a long time for this portion of the operation, may be taken without danger. If the tube is not then introduced it should be removed for a minute or two to allow the child to breathe, and then the operation may be repeated; but if the tube seems to be in the proper position, whether the operator is certain of it or not, the slide should be crowded forward so as to disengage the obturator, which is then withdrawn. Some cough will occur at once, and if the tube has not been inserted into the larynx, or if it has not been passed down so that the rim rests on the vocal cords, it is likely to be expelled and may be seen or felt in the back part of the mouth. If the tube has been properly inserted respiration will become easier in a few minutes. The operator then cuts one end of the silk thread, passes his finger behind the epiglottis, and holds the tube while the thread is withdrawn. Subsequently, if the tube be of sufficient size, the child may be expected to breathe easily, unless there be extension of the disease.

There is little probability that the tube will become stopped by the secretions, but if the breathing again becomes obstructed the tube must be removed and examined. Unfortunately, the tube is sometimes expelled by violent cough; and in cases which the physician cannot closely watch lives may be lost by this method which could have been saved by tracheotomy.

The tube may remain in the larynx as long as necessary to secure perfect respiration, as it causes little if any irritation. There are few cases of membranous croup in which the glottis will be free in less than four or five days, and it is not uncommon for the obstruction to remain ten or twelve days. Therefore, if no unfavorable symptoms arise, I would advise that the tube be left four or five days before removal; then if dyspnœa supervenes, it must be re-introduced, and it may have to remain ten or twelve days. No anæsthetic will be needed for the introduction of the tube, but one will occasionally be required for its removal.

Looking at the intubation of the glottis from our present standpoint, it seems well adapted for the following cases:

1. For diphtheritic and croupous stenosis of the larynx occurring in children under 3½ years of age.
2. For cases of these same affections in older children in which from any cause the physician wishes to defer the operation of tracheotomy.
3. For those cases in which consent to tracheotomy cannot be obtained.
4. For those cases in which proper nursing could not be secured.
5. For severe cases of spasmodic croup in children less than 10 years of age.
6. For simple stenosis of the larynx, not diphtheritic, in children.
7. With proper sized tubes it might be of value in the treatment of various forms of laryngeal stenosis in adults.

I have no hesitation in saying that Dr. O'Dwyer's instruments for this operation are far preferable to any of the numerous instruments for rapid tracheotomy. I can see no good reason why the tubes for older children may not be made much larger than they now are, and if this be practicable the greatest objection to this operation will be removed; however, there will be cases in which the tube may be coughed out, and in which, if the physician leaves the patient, the child may strangle before he can be found to return the tube. In such cases the physician would sometimes be culpable for not having done tracheotomy, and thus insured an opening for respiration.

The ease with which this method can be carried

out will doubtless secure its adoption in a large number of cases in which tracheotomy would not be advised, and thus it may be the direct cause of saving many lives. On the other hand, we must not forget that these very features are a source of danger, leading the physician to rely on this method in cases in which nothing less than tracheotomy could be of any avail, and thus many lives may be lost. I believe, however, that the method will do much more good than harm, and that within a few years it will find its proper place among the agencies for relieving suffering and prolonging human life. Even now I have such confidence in the operation that I think every community should have a set of these or similar instruments in the hands of some physician who has the good judgment to know when to use it.

64 State St., Chicago, January 27, 1886.

HABITUAL CONSTIPATION IN WOMEN—ITS CAUSES AND EFFECTS.[1]

BY H. J. HARRIMAN, A.M., M.D.,

OF REVERE, MASS.

One of the most frequent and obstinate troubles that the general practitioner is called upon to treat is habitual constipation. Even the large number of cases that are thus brought into notice are but a small part of those suffering from this cause, since a strange and unconquerable indifference to such a state keeps away all except those who are compelled to seek advice on account of other trouble, possibly the result of this state of the lower bowel. So frequently is this state associated with pelvic trouble, that the question naturally arises as to what relation habitual constipation has to the diseases peculiar to women. To inquire into this relation and excite discussion on this practical question is the object of this paper. With constipation, considered as a symptom, the medical profession are fully acquainted, but of constipation as a disease *per se*, which may be the predisposing if not the exciting cause of more serious trouble, they are inclined to be skeptical.

Is this state a *cause*, an *effect*, or simply an *accompanying circumstance* of pelvic trouble? It seems to the writer that its relation is that of a cause, and it will be so treated. The physiological functions of the body are wonderfully interdependent. Not one can fail to act in its normal way without influencing, either directly or indirectly, the action of every other. This influence may be exerted through the general system, through a reflex nervous influence, or mechanically. In the case of failure to empty the lower bowel with normal frequency, we find the pernicious influences of such a state exerted in each of these three ways.

Of the constitutional effects of such a state malnutrition and spanæmia are generally prominent. This is readily understood when we consider the function, or rather the perversion of function of the lower bowel. The colon, especially the sigmoid flexure, is intended to act as a depot for the retention of fæces until it is convenient that they be discharged. Normally its absorbing power is limited. Its excretion consists of mucus and some odoriferous elements of the fæces. When, however, the excrement is retained for days, and it may be for weeks, the functions of this organ are so perverted as to give rise to pathological processes. The fluid elements are absorbed into the circulation to be excreted by the other emunctories of the body; noxious gases are generated and reabsorbed, and there is created what might be called a vicious circle by the excretion and reabsorption of these noxious elements. An idea of the extent to which absorption goes on can be gained by comparing the bulk of fæces when a daily evacuation is gained, and the bulk when the bowels move but once or twice a week. In the latter case the amount is not greater than in the former.

The effects of such a state can be seen in the slow toxæmia which exerts a benumbing influence on the nervous system and depresses every function in the body. Many of the low, nervous manifestations which are usually characterized as reflex are due to this poisoned state of the blood. The strength fails; the appetite diminishes and the tongue is foul; there is more or less constant headache, a want of mental power, a constant drowsiness unrelieved by sleep, and fatigue upon the slightest exertion. Sleep is not refreshing but is disturbed by dreams and nightmares. The extremities are cold. Hypochondria and mental depression are common.

This state of the general health opens wide the door to all local troubles in the active organs of generation. The muscles and ligaments lose their tone and yield readily to such injurious influences as tight-lacing, heavy clothing, and indiscretions at menstrual periods. The circulation is slow and imperfect owing to the defective performance of the functions of the heart and lungs; and ovulation and menstruation, which nature intended should be painless processes, become sources of anxiety and distress. Nearly all writers on diseases of women agree that flexions and versions of the uterus may be due, in part at least, to habitual constipation. In anterior displacements the primary influence of fæcal accumulation may be mechanical, whereby the uterus is forced forward upon the bladder, giving rise to troublesome bladder symptoms. In posterior displacements and prolapsus the mechanical influence is of minor importance, but the evil is chiefly due to pressure from muscular action while straining at stool.

Thomas says: "Fæcal impaction may possibly produce flexion of the body and frequently causes the cervix to bend sharply forward." Speaking of cervical flexion he says: "It is generally produced by pressure directly exerted upon the uterus by tight clothing, which forces it against the concave surface of the vagina. This surface gives the impinging part a slant forward and keeps it thus bent. Habitual constipation increases this vicious curve, and the two causes combined often result in an unmanageable form of the affection."

Fæcal impaction may cause, or at least aggravate, menorrhagia and metrorrhagia by interfering with the portal circulation and producing congestion of the

[1] Read before the Gynecological Society of Boston, November 22, 1885

pelvic viscera. The author last quoted says: "My experience has furnished me with a number of cases in which fæcal impaction produced prolonged metrorrhagia which was cured by its removal.

Leucorrhœa may be due to the same cause acting in the manner just stated.

It is no easy matter to discriminate closely between the nervous symptoms due to the constitutional influences of such a state, and those due simply to reflex influences. Vaso-motor disturbances are very frequent. Variations of temperature have also been noticed. Gastralgia, ovarian neuralgia together with various hysterical manifestations, are often the result of a loaded colon and cured by its relief.

Some of the pernicious influences of habitual constipation seem to be due to a mechanical influence simply, as has already been stated. When the sigmoid flexure and rectum are loaded and distended the uterus is crowded forwards and dysuria results. The soft and pliable uterus of girlhood may be forced into abnormal positions and forms necessitating surgical interference. In rare cases the transverse colon has become so loaded as to be dragged from its attachments. It then descends toward the pelvis and thus increases the pressure on the organs of generation.

The causes of this unfortunate condition are not far to seek. The most of them are so well known as to render their repetition unnecessary. John Burne, writing in 1840, said that constipation was due more to indifference to the act of defecation than to any other cause. The experience of the profession to-day will, I think, verify this opinion. This cause, together with false modesty, indolent habits, vicious styles of dress and ignorance of hygiene are fully appreciated by medical men. There are, however, in addition to these, certain causes arising from the anatomical structure and physiological functions of women which render them peculiarly liable to troubles of this nature. At every menstrual period the uterus and ovaries are enlarged and tender, and press, to a greater or lesser extent, upon the rectum. The act of defecation produces pressure upon these sensitive organs and renders the act a painful one, and thus leads to neglect of this function. It is said that constipation is more prevalent in this country than in England on account of the fact that our comparatively dry climate favors the removal of the fluids of the body by evaporation, and thus diminishes the volume of excrementitious matter. However this may be, we know that a withdrawal of the fluid elements of the blood tends to foster if not to produce this condition. This is shown by the influence which lactation exerts whereby defecation is diminished in frequency.

The influences of frequently recurring pregnancies are unfortunate. During gestation the uterus presses upon the colon and sigmoid flexure and interferes with their normal action. The extreme stretching of the abdominal muscles weakens them, and thus renders almost useless these important auxiliaries in emptying the lower bowel. In some cases where many children are borne, the abdominal muscles may become so relaxed that the impregnated uterus may form a pendulous mass in front of the *os pubis*. The great pressure to which the rectum and colon are subjected during labor exerts a paralyzing influence upon the muscle of the bowel. In addition to this, the relaxed state of the pelvic viscera following labor offers a diminished resistance to the great distension of the lower bowel which is so often discovered in cases of long-standing constipation.

The nervous state at the climacteric, with its fugitive abdominal pains, and state of apprehension, causes women to dread and avoid any act which may seem to increase their distress. This leads them to neglect entirely or to slight the function of defecation.

Such are some of the causes and effects of this common trouble. It has seemed to the writer that in these days when local treatment of the uterus, both medical and surgical, is so popular, the attention of the profession might with advantage be directed to this state, and that more careful attention to the condition of the *primæ viæ* and general health would render the success of local treatment more certain and satisfactory.

MEDICAL PROGRESS.

THE TREATMENT OF CONGENITAL SYPHILIS BY THE OLDER AND NEWER METHODS.—PROFESSOR MONTI, of Vienna, contributes a valuable paper on this subject to the *Archiv für Kinderheilkunde*, Band vi., Heft 1. Of treatment by inunction, the oldest is that in which blue ointment is employed. It is still largely used; but the objection to it is that it oxidizes too readily in this form, and is then apt to produce eczema. Oleate of mercury is extensively used instead of the blue ointment; and mercurial plasters have been substituted by some, while Charcot, recommends mercurial soap. All those compounds are, however, more or less unsuited to the tender skin of infants, the least objectionable being the oleate of mercury. Dr. Monti has, however, had no personal experience of the soap. Moreover, inunction involves considerable risk of the system rapidly absorbing an excessive quantity of the drug, and in the case of very young infants this leads to acute anæmia. He has also come to the conclusion that the sudden death, which is not an uncommon incident in hereditary syphilis, occurs with far greater frequency where this has been treated by inunction. For these reasons, he has for some years ceased to use it in the case of children under one year. The next treatment under review is that by calomel. This also has a tendency to produce anæmia, and should, therefore, be given as a powder in combination with lactate of iron. This should be discontinued when the first symptoms have disappeared, and saccharated iodide of iron substituted until the spleen is no longer felt or the skin has resumed its normal color; but should the disease reappear in the skin, mucous membrane, or bones, calomel must again be resorted to. In some rare cases, such as those where there is great irritability of the intestinal tract, a subcutaneous injection of a freshly prepared mixture of calomel suspended in mucilage may be administered.

The treatment by corrosive sublimate gives very satisfactory results, provided it be not to long continued, in which case symptoms of gastric irritation will supervene. This drug is also administered in the form of a bath, which should contain about seven grains; but in the writer's experience, their effect upon the disease is very slow, and should therefore be accompanied by calomel internally, and in that way they appear to hasten the cure. The best mode of giving corrosive sublimate is by subcutaneous injection. The solution should consist of perchloride of mercury gr. jss., chlorate of soda gr. vj., and water 150 grains, and of this one-half to one syringeful should be used every day or every other day until the symptoms disappear, to be renewed upon their return. The punctures are best made upon the abdomen or chest, and must not be too close together.

The injection is in general well borne, and, according to Dr. Monti's experience, never produces mercurialism, and causes very little loss of flesh. It cannot be denied, however, that infants do not bear these injections so well as adults; even with the greatest care, it is not uncommon to find induration of the cellular tissue and abscesses at the seats of puncture. It is also not suitable for out-patients, because the mothers decline to bring the children after the first few times. Notwithstanding that the symptoms subside more rapidly under this treatment than under any other, the author has of late confined its use to cases that would not bear mercury internally.

Albuminate of mercury, as recommended by Bamberger, is preferable for hypodermic use to corrosive sublimate, provided the solution be clear; but it is excessively unstable, and, if used in a cloudy state, produces irritation and abscesses. Much the same objection applies to mercury-peptone, though it is rather more stable. Formamide of mercury (Liebreich) is unsuited to children. Protiodide of mercury produces excellent results, especially when combined in a powder with lactate of iron, and perhaps no other remedy acts so promptly upon syphilitic affections of the bones. Unfortunately, it produces diarrhœa and colic, and the addition of Dover's powder to the above compound soon ceases to have any effect. Consequently, Dr. Monti only gives it in cases where bone-affections exist from the beginning. Black oxide of mercury, as recommended by Henoch, was found to produce vomiting, and was therefore soon given up. The author has had only a limited experience of hydrargyrum tannicum oxydulatum (Ludwig), but is favorably impressed by it, more especially because it does not appear to affect the digestive organs. It is now a recognised fact, that hereditary syphilis can be cured by preparations of iodine as well as, though more slowly than, by mercury. It may be given as iodide of potassium, to which, however, there are on the whole insuperable objections, or as saccharated iodide of iron. The treatment of syphilis with this drug was favorably commented upon by the author in a paper on the subject in 1876, and his subsequent experience of it has confirmed this predilection. It is borne well by children of any age, improves their nutrition, and never produces iodism; but it is much slower in its action than mercury, and is therefore best suited for very chronic cases. It should be given as a powder; for, if the syrup be used, it is apt to produce diarrhœa. Three grains may be divided into ten powders, and a new-born child may have two or three daily, dissolved in milk.—*London Medical Record*, January 15, 1886.

THE TREATMENT OF PROFUSE HÆMOPTYSIS.—In an article on this subject, read before the Medical Society of London, DR. SAMUEL WEST gives the following summary of the principles of treatment:

1. *Rest* (*a*) of body generally, (*b*) of part diseased. Many of the indications under this heading will be met by the use of opium.

2. *Hæmostatics.*—(1) The topical astringents; (2) the vascular constringents. Topical astringents cannot be applied to the bleeding part of the lung, and if they act at all, it must only be as vascular constringents.

The belief as to the use of the vascular constringents in pulmonary hæmorrhage is probably based upon an incorrect theory of the pathology, and reasons have been given why they can be expected to do but little, if any, good. Ergot was probably introduced on account of its efficiency in controlling uterine hæmorrhage; but it is shown that the necessary conditions for its action do not exist in the lungs unless their action be by vascular constriction, and this is probably ineffectual.

As the risk of death in profuse hæmoptysis is not so much from loss of blood as from suffocation, and as profuse hæmorrhage tends to bring about of itself the conditions most favorable to its cessation, an attempt may be made to imitate these conditions in treatment. When a vessel is divided hæmorrhage ceases (1) from contraction of the vessel; (2) from clotting of the blood, aided by the great fall in blood-pressure which severe hæmorrhage induces.

1. *Contraction of the Bleeding-Vessel.*—The vessel is so diseased in hæmoptysis, that its muscular coat can no longer act at the diseased spot, and therefore this condition cannot be fulfilled.

2. *Clotting of the Blood.*—There is, so far as I am aware, no drug which, by internal administration, can increase the clothing power of the blood.

The effect upon the blood-pressure can be imitated in various ways.

1. By free blood-letting from artery or vein. This old-fashioned method of treatment is as rational in cases of suffocative hæmoptysis as in apoplexy, for in both cases the risk to life is not from the loss of blood, but from the mechanical effects of the hæmoptysis upon the organ involved.

2. If blood-letting be inapplicable, the same end may be aimed at by detaining the blood in some part of the body other than the part diseased; (*a*) for example, mechanically, as by the use of Junod's boot, or free dry cupping; (*b*) or by dilating some of the great vascular systems of the body, and making them act as temporary reservoirs for the blood; (*a*) the abdominal system (purgation); the cutaneous system; counter-irritation; possibly pilocarpin, or even nitrite of amyl. These two drugs dilate the vessels throughout the whole body, and might possibly be of great

service. Some objections in theory to their action have been considered.

3. The blood-pressure may be further influenced through the heart: (*a*) by means of the cardiac depressants, of which antimony is the most reliable; (*b*) by the nauseating emetics, though their action upon the heart is probably only a part of a more general action. Of the emetics, ipecacuanha was much used by Trousseau.

4. Lastly, dieting is of great importance. The principle of absolute rest and restricted diet, which is the essence of Tufnell's treatment for aneurism of the thorax and abdomen, is equally applicable and useful in pulmonary hæmoptysis.

Instead of giving a long list of drugs, or discussing in detail the various methods of treatment of hæmoptysis, I have endeavored in this paper to ascertain the conditions which have to be fulfilled, and to indicate the essential principles which should guide our choice of remedies. I have purposely avoided speaking of my own experience, desiring rather to elicit that of others; and although some, of the lines of treatment are, it is true, open to the objection that they are so far speculations, still it cannot be denied that our present treatment of hæmoptysis is far from satisfactory, and perhaps, from the nature of things, may be doomed to continue so. Speculation may, perhaps, suggest lines of treatment which experiment may follow out, and of the value of which observation alone is the true test.—*British Medical Journal*, January 16, 1886.

New Procedure for the Removal of Small Calculi from the Bladder.—Mr. Thomas Annandale reports the following case in which he adopted a new procedure for removing small vesical calculi from male children: A boy, aged 4¼, was sent to me on account of symptoms of stone in the bladder which had existed for about a year. The usual symptoms were present and well marked, and, upon sounding him, I detected a small and light stone.

On December 10, I put him under the influence of chloroform, and dilated urethra by passing Nos. 6, 7, 8 and 9 silver catheters in succession. The first three passed readily, but No. 9 was slightly grasped in its passage along the urethra. Before removing this last catheter, four ounces of antiseptic fluid (corrosive sublimate 1 to 4,000) were injected through it into the bladder. This catheter being withdrawn, a small lithotrite, having a diameter about equal to a No. 8 bougie, was introduced along the urethra into the bladder. After a little careful manipulation, the stone was seized, and fixed between the blades of the instrument. It was then found that, by depressing the handle of the lithotrite, its vesical extremity, together with the stone, could be readily felt through the abdominal wall immediately above the pubes. The lithotrite being held in this position, a small incision, an inch in length, was made in the middle line of the abdominal wall over the pubes, and for a short distance above it. The various tissues were divided, until the wall of the bladder was exposed at the point against which the blades of the lithotrite and the enclosed stone were pressing. A little further depression of the handle of the lithotrite caused the extremity of its blades covered by the stretched wall of the bladder to protrude through the wound in the abdominal wall; and a small incision having been made through the wall of the bladder by cutting upon the extremity of the lithotrite, the blades of the lithotrite, together with the stone, were pushed through the wound. The stone was here extracted from between the blades of the lithotrite; and the open extremity of a No. 7 India-rubber catheter was seized, and drawn into the bladder and along the urethra as the lithotrite was removed, thus leaving a drain for the urine to escape from the bladder. The wound in the abdominal wall was closed by means of two horsehair stitches, and a drainage-tube introduced into it so as to aid the escape of any urine which might flow from the bladder-wound. Irrigation with corrosive sublimate solution (1 to 2,000) was employed during the operation, and the wound and parts around were covered with a dressing of corrosive sublimate wool. The stone removed was about the size of horse-bean, of uric acid formation. For the first thirty-six hours after the operation, the urine was slightly tinged with blood, passed principally by the abdominal wound; but after this, it flowed through the catheter, which had been secured in the bladder.

Forty-eight hours after the operation both drainage-tube and catheter were removed, the patient not having had the slightest bad symptoms. For twelve hours after the removal of the drainage-tube and catheter, the urine came by the abdominal wound; but, after this, it passed almost entirely by the urethra, and the patient was running about the ward, perfectly well, on the tenth day after the operation.

It may be said that this is simply a suprapubic lithotomy, and so it is, but I maintain that it is a much less serious proceeding than the ordinary suprapubic operation, as the bladder is scarcely disturbed, and the wound made in it is very limited. Its advantages over lateral lithotomy are: 1. That the urethra, prostate, and neck of the bladder are left uninjured; 2. That it is a much more simple proceeding, and does away with the principal risks which have occasionally been encountered in performing the operation on children.

I confess that it requires a little manipulative dexterity to seize a small stone in a male child's bladder; but no greater dexterity is required in doing so than what every surgeon, professing to be an operating surgeon, should possess.

It is possible that in certain cases the same principle might be carried out, by bringing the stone to the neck of the bladder, opening the prostatic part of the urethra, and thrusting the blades of the lithotrite and contained stone into the perineal wound; but in the case of children there can, I think, be no doubt that the suprapubic method is preferable.—*British Medical Journal*, January 2, 1886.

New Operation for the Alleviation of persistent Deafness.—Dr. William H. Bates, of New York, in an article on this subject says that many cases of deafness are not benefited by thorough catarrhal treatment, inflation of the middle ear, the

use of Siegle's otoscope, an artificial opening in the drum-membrane, division of the tensor tympani, etc. He calls attention to an operation which has benefited a number of these obstinate cases. The operation consisted in puncturing or incising the drum-membrane in from five to ten different places. Simple punctures were made, or the drum-membrane was slit in various directions. The operation was repeated as soon as the openings in the drum-membrane had healed. The size and freedom of the incisions must be determined after the first operation for each case.

For the operation he employed a Graefe cataract-knife with a long shank. It is important that the knife be *sharp*, and to make this certain he often used a freshly sharpened knife for each puncture. Pain was avoided by this precaution. A dull knife, or the paracentesis instruments sold in the shops, caused more pain than the patients could bear.

Cocaine was not necessary when the knife-blade was in proper condition, and this remedy would not prevent pain when the knife was dull.

The result of this operation is to leave a number of cicatrices in the drum-membrane; the subsequent contraction of these producing a tension by which the membrane is drawn out. The membrane frees itself from adhesions in this manner, and in many cases loosens the anchylosed ossicles. The various benefits of paracentesis, as formerly employed, are not only obtained but much increased. It is not an improvement the result of a perforation of the drum-membrane alone, which, as is well known, is often doubtful and transitory, but the subsequent healing of the openings is part of an improving process. The operation, suggested by that of paracentesis, differs from it in the simultaneous number and extent of the incisions, as well as in the purpose for which it is resorted to, and in the immediate and subsequent results.—*New York Medical Record*, January 23, 1886.

THE INFLUENCE OF ALCOHOL AND OF MORPHINE ON PHYSIOLOGICAL OXIDATION has been studied by Sumanowsky and Schoumoff. Adopting Sieber and Nencki's suggestion, the oxidation of ingested benzol to phenol was taken as a measure of the systemic oxidation. The elimination of phenol lasts from two to four days. In the case of a dog which normally excreted 0·283 to 0·248 gramme of phenol for every gramme of benzol ingested, the administration of 0·3 gramme of alcohol per kilogramme of body-weight reduced to the elimination to 0·165 gramme; while an increase in the alcohol to 3·01 grammes per kilogramme reduced the phenol eliminated to 0·125 gramme. On the other hand, the administration of 0·02 gramme of morphine hydrochlorate per kilogramme increased the phenol to 0·309 gramme. In a man, aged 27, two grammes of alcohol per kilogramme of body-weight reduced the elimination of phenol, after the ingestion of two grammes of benzol, from 0·82 to 0·33 gramme. The morphine therefore seems to increase the oxidizing powers of the system, while alcohol correspondingly decreases them. The quantity of urea excreted appears also to be diminished by alcohol, although the excretion of urea cannot be taken as a measure of organic oxidation. Diminished oxidation, produced by constriction of the air-passages, which increases the elimination of urea, lessens the amount of benzol oxidized to phenol in the system. In none of these cases, it may be said, could more than traces of the alcohol ingested be discovered in the urine.—*London Medical Record*, January 15, 1886.

THE PREVENTION OF MYOPIA IN SCHOOL CHILDREN.—It is now tolerably well established that shortsightedness is developed and increased in a certain direct relation to the amount of school-work done by children. For the prevention of myopia, Fuchs, of Liège, in a prize essay, quoted in the *Birmingham Medical Review*, gives the following directions. First in importance is the arrangement and lighting of the schoolroom.

"The principal windows in England should look to the south or south-east. The long axis of the room should run north and south. Every scholar should, from his place, be able to see some portion of the sky. Light from above is the best, and, except in hot climates, glass roofs are very advantageous. The chief light must come from the scholar's left side. The height of the top of the window from the floor should not be less than two-thirds the width of the room. The total window-surface should bear to the area of the floor a proportion of at least 1 to 5. In artificial lighting by gas, every burner must have a glass chimney and a shade, the latter arranged to reflect the light down upon the desk, and to screen the scholar's eyes. There should be about one burner to every four scholars."

It is most important that the eyes should not be approximated too closely to the book. The proper position is that in which the shoulders and pelvis are parallel with the edge of the desk, and the head upright or bent but slightly forward. As to the construction of desks and seats, there must be several sizes, to suit scholars of various ages; the distance between seat and desk, in the vertical direction, must be but little greater than the distance between the elbow and the ischial tuberosity. The edge of the desk must overhang the seat about two inches; the scholar can then sit upright. The surface of the desk must slope about 1 in 5, to obviate the bending forward of the head; and the breadth should not be less than 15½ to 16 inches. All stooping should be avoided, and the types used must be perfectly legible.—*British Medical Journal*, January 16, 1886.

SPARTEINE IN HEART DISEASE.—PROF. GERMAIN SÉE has recently subjected Laborde's deductions from experiments to the test of clinical trials, the patients being two persons with degeneration of the cardiac muscle, one with mitral stenosis, one with mitral insufficiency, one with aortic stenosis, and one with cardiac asthma and albuminuria. From the action of the drug in these cases he concludes that sparteine sustains the action of the heart, improves its rhythm, and accelerates its movements.—*N. Y. Med. Journ.*, January 2, 1886.

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THE EDITOR OF THIS JOURNAL would be glad to receive any items of general interest in regard to local events, or matters that it is desirable to call to the attention of the profession. Letters written for publication or containing items of information should be accompanied by the writer's full name and address, although not necessarily to be published. All communications in regard to editorial work should be addressed to the Editor.

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THE DIVISION IN THE PROFESSION OF NEW YORK STATE ON CODES OF ETHICS—ITS BEARING ON THE INTERNATIONAL CONGRESS DIFFICULTY.

It has been asserted that much of the trouble with regard to the organization of the International Medical Congress has been due to dissensions, which have existed and which now exist in the profession in the State of New York; and it is assumed by some that these dissensions are little more than a local quarrel, having no proper relation to the profession at large or to the proposed organization of the Congress. Although the profession of the State of New York is certainly divided in opinion on the question of medical ethics, the quarrel—if one have existed—has long since disappeared from public view. That there actually is a division of the profession in New York is shown by the existence of two distinct State medical organizations. The Medical Society of the State of New York, organized by act of Legislature in 1806, in its volume of "Transactions" for 1884 showed a total active membership of 392. In 1882, this Society repealed the Code of Ethics of the American Medical Association. In 1884 the New York State Medical Association was founded as a voluntary organization. In its volume of Transactions for 1884, the Association showed a total active membership of 514. This Association adopted the Code of Ethics of the American Medical Association as a fundamental part of its organization.

Inasmuch as the condition of the profession in the State of New York is supposed by some to have a bearing upon the organization of the International Medical Congress, it is of interest to the profession at large to know, if possible, the exact status of the two parties into which the regular profession is said to be divided. The New York State Medical Association is in affiliation with the American Medical Association, and with the regular profession of the United States. The Medical Society of the State of New York is no longer in affiliation with the American Medical Association, for the reason that it does not accept the Code of Ethics of the Association. So far as the so-called division of the profession in the State of New York is concerned, we shall give to our readers the facts as they appear in publications readily accessible, with no expression of opinion upon the questions involved. If these facts have any proper relation to the organization of the International Medical Congress, this will appear without argument; and certainly the profession of this country and of other countries should be made acquainted, as nearly as possible, with the exact condition of the profession with regard to medical ethics.

The provision of the Code of Ethics of the American Medical Association, which constituted the main subject of discussion in New York, refers to consultations and is embodied in the following:

"But no one can be considered as a regular practitioner or as a fit associate in consultation, whose practice is based on an exclusive dogma, to the rejection of the accumulated experience of the profession, and of the aids actually furnished by anatomy, physiology, pathology, and organic chemistry."

In 1882, by the two-thirds vote required, the Medical Society of the State of New York repealed the Code containing this provision, and adopted the so-called "New Code," which has the following provision with regard to consultation:

"Members of the Medical Society of the State of New York, and of the medical societies in affiliation therewith, may meet in consultation legally qualified practitioners of medicine." (The phrase "legally qualified practitioners of medicine" introduced here we will continue to use throughout this article, although there is no law in this country establishing a *legal standard* of *qualifications for practitioners* of *medicine* in the same sense as in the countries of Europe. With very few exceptions, our laws regulating the practice of medicine are practically simply registration laws, requiring all sorts of practitioners, *regular* and *irregular*, to register their credentials in the clerk's office of the county in which they practice and obtain a license which gives them authority to practice, without furnishing any proof that they have either adequate scientific or professional attainments for the practice of medicine.) The "New Code" was

adopted in the Medical Society of the State of New York by a vote of 52 to 18, 70 members being present and voting. In 1884, an effort to repeal the "New Code" and to reëstablish the Code of the American Medical Association was defeated by a vote of 123 to 105, 228 members being present and voting.

The exact status of "legally qualified practitioners of medicine" with whom "members of the Medical Society of the State of New York, and of the medical societies in affiliation therewith" are now permitted to consult, and with whom many so-called regular physicians in the State of New York do now freely consult, was fixed in 1880, nearly two years before the adoption of the "New Code," by an act of Legislature entitled "An Act to Regulate the Licensing of Physicians and Surgeons." It may be assumed that those who advocated the adoption of the "New Code" were aware of the character of certain practitioners with whom consultations were permitted under the "New Code," inasmuch as certain of the advocates of the "New Code" were active in preparing the bill under which practitioners are now registered in the State of New York. In 1883, Messrs. Caswell, Hazard & Co., druggists, of New York City, printed and distributed a list of "Registered Physicians in the County of New York, compiled and alphabetically arranged from the official list in the office of the County Clerk, to January 14, 1881, revised to January 1, 1883." This list, with the report of the Illinois State Board of Health on "Medical Education and Medical Colleges in the United States and Canada, 1765–1885," giving the standing of the medical colleges of the United States, and the "Medical Register of New York, New Jersey and Connecticut," for 1883–84, has been used in the following analysis. The "Medical Register" is supposed to contain the names of all legally qualified regular physicians in the County of New York. The number of such physicians in the "Register" of 1883–4 was 1,661. The register in the office of the county clerk contains not only the names of the regular physicians who are named in the "Medical Register," but the names of all "legally qualified practitioners of medicine."

An analysis of the county clerk's register shows the following: 388 irregular practitioners are registered. Of this number, 38 are graduates of regular medical colleges, but are members of the "Homœopathic Society of the County of New York," while 350 are graduates of irregular medical colleges. The following colleges are the irregular institutions named in the register. Notes of the status of each college, where this is not plainly indicated by the title of the institution, are copied from the report of the Illinois State Board of Health on the medical colleges in the United States, 1765–1885.

1. Eclectic Medical College, New York. 2. Syracuse Medical College (Eclectic). "Organized 1849, extinct, 1855." 3. United States Medical College, New York (Eclectic). "Organized in 1878, in a manner that has since been declared illegal by the State Supreme Court. Extinct since 1882." 4. Philadelphia University of Medicine and Surgery (Eclectic). "Incorporated in 1859. Fraudulent. The sale of diplomas was stopped by legal process, and the arrest of Miller and others in 1880." 5. Eclectic Medical College, Cincinnati, Ohio. 6. Bennett College of Eclectic Medicine and Surgery, Chicago, Illinois. 7. New York Medical College for Women (Homœopathic). 8. Homœopathic Medical College, New York. 9. Hahnemann Medical College, Philadelphia, Pennsylvania. 10. Worthington Medical College, Ohio, afterward the Eclectic Medical Institute. 11. Metropolitan Medical College, New York (Eclectic). "Organized in 1852; incorporated March, 1857. Charter repealed April 12, 1862." 12. Hygieo-Therapeutic College, New York. "Extinct." 13. Homœopathic Medical College, Cleveland, Ohio, and Western Homœopathic Medical College, afterward consolidated under the name of the Homœopathic Hospital College. 14. Eclectic Medical College of Pennsylvania. 15. Electro-Therapeutic Institute of Philadelphia. 16. St. Louis Eclectic Medical College. "Organized in 1874—extinct in 1883. Closed by legal process." 17. Hahnemann Medical College, St. Louis, Missouri. 18. Massachusetts Medical College. No information. 19. Homœopathic Medical College, Leipsic. No information. 20. Physio-Medical College, Cincinnati, Ohio. "Organized in 1836; graduated classes until 1880. Extinct." 21. American Institute of Phrenology. No information. 22. Germantown Medical College, District of Columbia. No information. 23. Hudson University, Cleveland, Ohio. No information. 24. Mexican Homœopathic Institute. No information. 25. Ohio Botanic Medical College. No information. 26. New England Female Medical College, Boston, Massachusetts (Homœopathic). 27. Penn University, Philadelphia, Pennsylvania. "Fraudulent. Extinct." 28. New York State Homœopathic Medical College. No information. 29. American University of Philadelphia. "Incorporated in 1867. Fraudulent. Extinct. The sale of diplomas was stopped by legal process, and the arrest of Buchanan in 1880." 30. American Medical College of St. Louis (Eclectic).

31. Pulte Medical College, Cincinnati, Ohio (Homœopathic). 32. New York Ophthalmic Medical College. No information. 33. License by Professor Pfeiffer. No information.

If it be assumed that the profession of the State of New York is divided into two classes, these classes may properly be defined—at least so far as can be judged from what has been published regarding the troubles in New York—as one, composed of members of the Medical Society of the State of New York, and others, who sympathize with the so-called New Code of Ethics; and the second, composed of Fellows of the New York State Medical Association, and others, who adhere to the Code of Ethics of the American Medical Association. The "New Code" party admits the propriety of professional recognition of and of free consultation with the 388 practitioners, legally qualified to practice, but generally regarded as irregular, registered according to law, and with irregular practitioners registered in other counties. The "National Code" party refuses professional recognition of and consultation with any but regular physicians in good standing.

The questions which have divided the profession of New York—which seem to be not without interest and importance to the profession at large—were brought indirectly before the meeting of the American Medical Association in 1885, following the publication of the rules and preliminary organization of the Ninth International Medical Congress, by what is known as the Original Enlarged Committee of the Association. This committee appointed 56 physicians from New York as officers of the Congress and of the Sections. Of this number, 27 were on record as adhering to the "National Code," 20, as having adopted the "New Code," and the remaining 9, either as in favor of no code of ethics or as uncommitted or unclassified. This classification is taken from a publication issued by a body of physicians in New York City, which afterward organized the New York State Medical Association. The American Medical Association decided that the Original Committee appointed in 1884 exceeded its powers in appointing the officers of the Congress; and, at its meeting in 1885, the Association enlarged the Original Committee by adding members representing different sections of the United States, and instructed the Committee, thus enlarged, to "review, alter, and amend" the work of the Original Enlarged Committee, and to appoint the officers of the Congress.

The New Committee held several meetings, made a preliminary organization of the Congress, and entrusted the details of the further organization to an Executive Committee composed of the titular officers of the Congress and the Presidents of Sections, with power to increase its membership to a total number not to exceed thirty. The Committee on Organization having thus completed its necessary work, put the affairs of the Congress absolutely in the hands of this Executive Committee, which Committee is now perfecting the organization of the Congress in accordance with the rules adopted by the Committee of the American Medical Association.

The rules of the Congress admit as members all regular physicians without restrictions as regards opinions on the question of medical ethics; but the Committee virtually acted in accordance with what appeared to be the sense of the body by which it was appointed, which was "that it should place no man in any official position who is in direct opposition to the Code of Ethics of the American Medical Asssociation" and of all the affiliated State Medical Societies in the United States. The present status of the organization of the Congress is that the so-called New Code representatives from New York are freely eligible as members of the Congress. The demand of certain members of the profession, who have declined to take any part in the Congress, seems to be that all the officers appointed by the Original Committee shall be restored, including the "New Code" officers from New York, and that the organization of the Congress shall be put back into its original form.

If the question involved be one of principle, that principle is whether or not members of the regular profession who advocate consultations with any and all legally qualified practitioners, including such as are registered in the County of New York from the irregular colleges, shall be recognized by appointment to offices in the Congress. If the question relate merely to individuals, it resolves itself into one of the appointment as officers, by a Committee originally derived from and appointed by the American Medical Association, of members of the profession who are in direct opposition to its Code of Ethics.

The foregoing is a simple statement of what appear to be the relations of the profession of New York to the organization of the next International Medical Congress, giving the condition of medical matters in the State as it appears from printed records and documents, without trending upon the questions of geographical distribution of offices and the proper functions and powers given by the American Medical Association to its Original Committee on Organization of the Congress.

"THE MITRAL CARDIAC MURMURS."

Under this title is an admirable contribution by DR. A. FLINT, SR. to the January number of the *American Journal of the Medical Sciences*. As stated by its author, the paper is not designed to add any new facts to what is already known of the subject, but merely to call the attention of the profession anew to some of the characters of heart murmurs belonging to the mitral area. The paper is written in the author's happiest style, and would repay every general practitioner for its perusal.

Mitral murmurs are divided by the author into four classes as follows: Mitral regurgitant, mitral non-regurgitant or intraventricular, mitral presystolic, and mitral diastolic murmurs. A systolic murmur which is heard with greatest intensity at or near the heart's apex is of so common occurrence as to be familiar to almost every physician, and is generally considered to denote incompetence of the mitral valves. In the majority of cases this murmur is propagated to the left and is audible upon the back. It is accompanied, too, with an accentuation of the second pulmonary sound and demonstrable enlargement of the right ventricle. In such a case there could be no reasonable doubt thrown upon the existence of an insufficiency of the bicuspid valves. According to Dr. Flint there may be heard at times a systolic murmur, having its maximum of intensity at or near the apex, which, however, does not depend upon a regurgitation of blood into the auricle. It is produced within the left ventricle, and hence is termed by Flint "intraventricular" or "non-regurgitant." He does not attempt to account for its production in all cases, but thinks it might occur if there were a deposit of fibrine upon the ventricular aspect of the valves as the result of endocarditis.

In support of the existence of such a murmur, he cites a case reported by Dr. Janeway, of New York, in which the necropsy showed that the mitral systolic murmur heard *intra vitam* must have depended for its production upon a tendonous band which stretched across the cavity of the ventricle, since the valves were competent. Dr. Andrew H. Smith attributes the murmur in question to the friction of the opposed edges of the valve-segments. But this theory Dr. Flint does not consider adequate to its explanation. That a non-regurgitant murmur may exist is, according to the author, borne out by the clinical fact that in such cases the secondary and disastrous results of regurgitation never develop. George Balfour, on the contrary, regards such cases as instances of functional, not organic incompetence of the bicuspid valves, depending upon the relaxation of the ventricular walls and consequent stretching of the auriculo-ventricular orifice. With this theory Dr. Flint is by no means in accord. As might be expected, the differential diagnosis of a mitral regurgitant or non-regurgitant murmur is not always easy. But, if Flint's view be correct, that a mitral systolic murmur may exist without incompetence of the valves, there can be no increase of pressure within the pulmonary circuit, and hence no accentuation of the second pulmonary sound. This, it seems to us, ought to prove a valuable aid in determining the true nature of such a murmur. In some cases, the author says, a non-regurgitant may be combined with a regurgitant murmur. It is then to be distinguished by its softness and blowing quality.

Of the presystolic murmur Dr. Flint has much to say. His description of its character corresponds with that of other competent observers, viz.: that it is rough and usually loud. He denotes it as "vibratory or blubbering," thereby meaning the same as those who call it "rolling," "grinding," or "churning." As to the mode of its development, however, all observers are not in accord. Flint asserts his belief in its dependence upon that condition of the valves in which the edges are glued together, thus forming a funnel-shaped sack with a button-hole slit. Hilton Fagge, in "Reynolds's System of Medicine," appears to regard this distortion of the valves as that most often found in cases in which a rough presystolic murmur was heard during life. Douglas Powell has essayed to prove that the most usual form of valve associated with this murmur is what he has termed the "diaphragmatic valve." In this condition the valve is stretched diaphragm-like across the ostium, leaving a constricted opening. Balfour adopts this theory of Powell, and plainly states in the present edition of his "Lectures on Diseases of the Heart" that in the majority of cases with a rough presystolic murmur the valves do not present the funnel-shape described. It is probably within bounds to state, however, that the majority of observers agree with Flint upon this point.

There is another question pertaining to the presystolic murmur in which the author appears to stand alone: It is as to whether a presystolic murmur may ever be pesent without stenosis of the mitral orifice. Dr. Flint has reported three cases in which he observed such a murmur, yet in which the autopsy revealed no constriction of the *ostium venosum sinistrum*. In two of the cases the valves were healthy, while in the third there were small vegetations upon the auricular aspect of the curtains at their base. In all three cases aortic incompetence existed and

had been diagnosticated *intra vitam* from its characteristic murmur. Balfour openly charges the author with inability to recognize a presystolic murmur and with having confounded it with the aortic diastolic one present in all of the cases. To accuse so competent and experienced an observer as Dr. Flint of such ignorance and negligence is discourteous, to say the least, and it is not strange that the author should feel incensed. Whether his explanation of the phenomenon be tenable or not, the correctness of his observation ought not to be doubted.

Lastly, the author directs attention to the not infrequent presence of a mitral murmur which is diastolic. That is, it occurs at or just after the second sound and is separated by an appreciable interval from the succeeding ventricular systole. This is as definitely characteristic of mitral stenosis as a presystolic murmur, and has been observed to develop after the subsidence of the latter. It is somewhat soft and bellows-like in quality. Bramwell attributes its production at the beginning of diastole, to the increased force imparted to the inrushing stream by the aspiration of the relaxed ventricle. The author, however, is not inclined to endorse this explanation. Whether this mitral diastolic murmur can be accounted for satisfactorily or not, the occurrence of such a phenomenon cannot be denied, and in the author's opinion, is entitled to the classification accorded to it, except indirectly. Dr. Flint says nothing concerning another diastolic murmur that is occasionally heard with maximum intensity at the apex, yet is not generated at the mitral orifice. This is that very rare form of aortic regurgitant murmur first described by Balthazar Foster and recognized by both Balfour and Fothergill. In case the posterior segment of the aortic valves be ruptured, the ensuing murmur is said to be loudest at the apex instead of at the middle of the sternum. Foster is said to have made the diagnosis of incompetence of the posterior cusp in one case, in which it was verified by the necropsy. Although this murmur is not mitral in the sense of being generated at the mitral orifice, it is such with respect to the area of its greatest intensity, and hence might mislead an observer not acquainted with the possibility of its occurrrence.

Dr. Flint's paper is succinct and full of matter for reflection. Among other things the thought is suggested by the wide divergence of authors concerning the mode of production of certain murmurs, that perhaps all of them may be right. If Savart's theory be correct, viz: that intracardiac as well as intravascular murmurs are caused by the audible vibrations of fluid veins, there is reason to suppose that a variety of conditions may produce these sonorous fluid veins. Accordingly, in the first case reported by Dr. Flint, the vegetations upon the auricular surface of the mitral curtains may have generated such fluid veins, even without stenosis. Similarly, in the other cases, conditions dependent upon some peculiarity in the stream regurgitating from the aorta may have produced fluid veins at the very instant of the auricular systole, and thus given rise to a presystolic murmur. Also, may not a variety of conditions produce non-regurgitant or intraventricular murmurs? Moreover is it wise to attempt to explain all murmurs occurring in the pulmonary area as the result of one and the same physical condition? May not Naunyn's theory, which Balfour defends, be true of some cases, while in others the murmur is hæmic and located in the pulmonary artery?

Much as we flatter ourselves we know of the physical diagnosis and of the pathological conditions of the heart, we are yet wofully ignorant of many things which more extended clinical observation, supported by post-mortem examinations, will probably reveal to the ken of future generations.

FELSENREICH'S MODIFICATION OF ALEXANDER SIMPSON'S AXIS-TRACTION FORCEPS.

We desire to call attention to Dr. T. Felsenreich's paper, entitled "Experiences with the Axis-Traction Forceps," appearing in another column, for two reasons: 1. It is a valuable contribution to the literature of the subject of the axis-traction forceps by an accomplished obstetrician of very large experience; 2. It settles conclusively a question, in regard to which some difference of opinion seems to exist. Dr. L. E. Neale of Baltimore, presented to the Medico-Chirurgical Faculty of Maryland, in Baltimore, and the American Gynæcological Society, in Washington, 1885, a model of an axis-traction forceps, which he has since decribed under the title, "An Obstetric Forceps," in the *American Journal of Obstetrics*, September, 1885.

It was asserted in our editorial columns, September 26, 1885, that the instrument as described by Dr. Neale in the journal mentioned, was identical in all essential details with Felsenreich's modification of Alexander Simpson's axis-traction forceps; that this valuable instrument (Felsenreich's modification of Alexander Simpson's axis-traction forceps) was used in Braun's clinic, exhibited in courses on operative obstetrics, and exposed for sale by Mr. J. Leiter during Dr. Neale's sojourn in Vienna, a considerable period of time prior to the construction of the so-

called Neale axis-traction forceps; that Felsenreich's modification could scarcely have escaped the observation of such an acute, zealous, and industrious student as Dr. Neale; and, finally, that Dr. Neale's allusion to Dr. Felsenreich[1] in the paper mentioned, was disingenuous.

Some correspondence ensued between Dr. Neal and the editor of THE JOURNAL, which resulted in a communication to Dr. Felsenreich, now Docent in obstetrics and gynæcology at the University of Vienna. Dr. Felsenreich's reply is published without comment, as the point in question is discussed in no unequivocal terms.

SOCIETY PROCEEDINGS.

MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA.

Stated Meeting, January 13, 1886.

THE PRESIDENT, C. H. A. KLEINSCHMIDT, M.D., IN THE CHAIR.

T. E. MCARDLE, M.D., SECRETARY.

DR. BERMANN presented a number of

NASAL POLYPI

removed from one person. These tumors, he said, were not gelatinous, but fibrous, and showed under the microscope a large number of connective tissue corpuscles. The patient was supposed to have had bronchial catarrh. She suffered from asthmatic attacks and was unable to breathe through the nose. Her general health was much affected and she presented quite a decrepit appearance when first she came to his office. He removed the polypi with a snare, taking away as many as he could see at each sitting. He cauterized the points of insertion with tri-chlor. acetic acid, and believed that the tumors would not return. The proceeding was painless. At first he used cocaine, but afterwards dispensed with it on account of its numbing influence on the patient's tongue. He related the salient points of a similar case which had been under his care in Baltimore.

DR. J. FORD THOMPSON did not understand why Dr. Bermann should use a snare when forceps is so much more convenient and simple. He himself had removed polypi with forceps which could not be reached with the snare. He could thus remove as many as he desired at one visit.

DR. BERMANN thought the forceps too rough an instrument for such delicate work. Moreover, in his experience it was not as satisfactory as the snare, for the forceps could not reach points which could be reached with the latter instrument; for example, the lateral surface of the turbinated bone between it and the antrum.

(To be concluded.)

[1] "The idea of its construction is not *entirely* original with me, as the button-hole joint for the traction rods was first shown to me by Dr. Felsenreich, first assistant to Prof. Carl Braun, of the Vienna clinic, in 1882." —The American Journal of Obstetrics, September, 1885.

Stated Meeting, January 20, 1886.

THE PRESIDENT IN THE CHAIR.

DR. H. C. YARROW read the history of a case of

PAPILLOMA OF THE BLADDER.

The patient, a male, aged about 45, noticed some fourteen years ago an irritability of the bladder, a constant desire to micturate, with scanty flow, and after a time a profuse discharge of bloody urine, subsiding within variable periods of time under the administration of appropriate medicines. This condition of affairs continued until the winter of 1884, when he came under Dr. Yarrow's care, and he supposed at this time that he was suffering from renal hæmorrhage. He was examined very carefully with a view to determine the origin of the bleeding, and all possible sources were excluded with the exception of a surmise that a tumor or villous growth perhaps existed. His urine was frequently examined microscopically, but no signs of a growth were discovered. All sorts of hæmostatics were employed in addition to local remedies, but the bleeding still continued, until finally it was decided to try and remove a portion of the growth if one was present, by means of a searcher, or short curved sound. Sweeping this instrument carefully around the inside walls of the bladder, it met with an obstruction at the lower portion of the posterior wall, but it was impossible to say whether there was a growth or simply a rugous condition of the wall. The beak of the instrument was passed over it several times, and then all further manipulation was abandoned. There was very free hæmorrhage the next day, and in the afternoon several shreds of tissue were passed; these being submitted to microscopical examination, proved to be portions from a papillomatous growth. The diagnosis was submitted to the patient, and he was advised to have the growth removed; but the bleeding ceasing after awhile, he concluded not to have anything done.

He had no further return of serious hæmorrhage until November, 1885, when he again placed himself under Dr. Yarrow's care. He was again advised that an operation should be performed, especially as the diagnosis was confirmed by the examination of another shred from the growth, but he hesitated until grave fears were expressed for his life. He was losing daily an appalling amount of blood, and was becoming manifestly weaker day by day, notwithstanding all known remedies were used to control the bleeding. He finally agreed to an operation, and for reasons best known to himself preferred to visit Philadelphia and have it performed by Dr. D. Hayes Agnew. At the patient's earnest request Dr. Yarrow accompanied him to that city, and on December 16 he was operated upon in the presence of the class. The operation was the one proposed by Sir Henry Thompson, called by the old French surgeons the boutonnière, and may be briefly described as fol-

lows: The patient having had the perineum shaved, and being anæsthetized, the bladder being filled with water, was placed in the the lithotomy position, and a medium staff, short curved and widely and deeply grooved, was passed into the bladder, and was there firmly held hooked up under the pelvis by an assistant. The operator, seated, passed the left index finger into the rectum, feeling with its tip the position of the staff and placing the point of the finger on the apex of the prostate as a guide. Then with a long, narrow, straight-backed bistoury, a vertical incision was made through the skin and cellular tissue in the line of the raphé, an inch and a quarter long, the lower border terminating three-quarters of an inch above the anus. The bistoury was entered, cutting-edge upwards, horizontally at the lower border of the incision above the bowel, and parallel with it, and the point was directed inwards until it penetrated the membranous portion of the urethra, entering the groove of the staff. The urethra was then incised on the staff for a short distance, taking care not to wound the bulb. The knife was withdrawn and a gorget-like director passed into the groove of the staff and pressed firmly but gently along the urethra into the bladder. The staff was then withdrawn and the left index gently insinuated along the director into the bladder; the director was withdrawn, and the right hand was used to make firm supra-pubic pressure, and bring all parts of the bladder within reach.

The growth on the posterior wall was at once found by Dr. Agnew, who proceeded to remove it by using one of Thompson's forceps. This growth was nearly as large as an English walnut. Further exploration revealed, on the anterior wall of the bladder, another and a larger growth, which was also removed, the two masses together being half as large as a man's fist. The bladder was washed out with carbolized water. some carbolized cotton applied to the wound, and the patient sent to his bed. During the operation not over four ounces of blood were lost. No untoward symptoms presented themselves at any time while he remained in the hospital, and on December 31st he returned to his home in Washington, apparently well, the incision having entirely healed. On the third day after the operation urine passed through the urethra without a tinge of blood, and at the present time he seems perfectly well, being no longer troubled with symptoms of vesical distress, which made life a burden to him.

Comparing this operation of Thompson's with the suprapubic or with the ordinary lithotomy operation, I think the advantages are all in favor of the former. The bladder and its neck are not injured in any way, and, in short, it is one of the simplest and least dangerous of surgical operations. In the suprapubic operation it is almost always necessary to make a counter-opening in the perineum for drainage, and even if this be done, statistics show that many patients perish of peritonitis. If the growth be so large that it will not pass through the vesical neck, it may be removed piecemeal, divided within the bladder, or removed by lithotomy operation, or a suprapubic incision. In some cases Dr. Thompson uses small saw-like instruments like Hey's saws to remove the growth, but in the majority of cases the forceps are sufficient. In case of bleeding from the base of the tumor after removal he uses syringes of peculiar form intended to make a direct application of some one of the hæmostatics. In Dr. Yarrow's case all bleeding stopped so soon as the growths were crushed off. With regard to the statistics of the operation, he will give the results of the twenty cases of vesical tumors operated on by Sir Henry Thompson up to the year 1884, in his own words: "Of the twenty cases of tumor, two were in women: one of these died in three days of total suppression of urine; autopsy showing advanced disease of kidneys (one contained a large calculus), and that no injury was inflicted upon the bladder. The other is now in excellent health, having entirely lost her painful symptoms; observing a few drops of blood, occasionally, after more exercise than usual. More than two years have elapsed since the operation. Of the eighteen male cases, five died within three weeks after the operation; three others at periods of some months after, two of them from malignant disease developed elsewhere. The other nine are living; one of these, from whom I removed a tumor in the autumn of 1882, I operated on again, removing a larger growth than the original one last February, and he has again recovered. In four cases no attempt was made to remove the tumor, it being manifestly impossible to do so, but only to diminish it as far as practicable with safety; all these recovered well, and are rather better than before. Of the remaining four, one has had no return whatever, four years having elapsed since the operation; a second has slight signs of a return, one year and a quarter since operation, but works hard for his living at 64 years of age; a third who, like the last, was at death's door from loss of blood when I operated, has greatly improved, and is actively employed, but has recently shown some disposition to bleed after exercise, nearly a year since operation. The fourth was greatly improved, and returned to the active life for which he was before disqualified. The others have too recently been operated on to furnish any material fact to be reported. More ample details are furnished in the table of cases. . . . . I may thus briefly sum up the record of the numerous facts related: For every one of these patients with tumor, in the natural order of events, one result only was possible. Left to themselves, without surgical aid, death inevitably awaited each; a fate not merely certain, but involving protracted suffering."

A portion of the growth removed from the patient whose case has been reported has been examined by Dr. Gray, of the Army Medical Museum, and he reports as follows: "The enclosed specimen is a section taken from the tumor of bladder removed by Dr. Agnew December 16, 1885. It is a fimbricated papilloma, under the microscope it shows a number of single and branched papillæ. The core of these papillæ is made up of delicate connective tissue covered with layers of columnar epithelioma, which rests on a delicate basement membrane. The growth is usually known as a soft papilloma."

In conclusion, Dr. Yarrow said that when we read

accounts of certain operations described by the great masters of surgery, in the mere reading they appear very simple, but when we come to put into practice the unusual dexterity needed we occasionally find the work much more difficult than we supposed. He does not think such is the case with regard to Thompson's operation. Anticipating that his patient would sooner or later consent to an operation, he practiced it upon the cadaver, hoping to do it for him himself, and was amazed to find how simple and easy the whole procedure was; and he is sure this will be the experience of any of the members of this Society who may wish to try it.

DR. J. FORD THOMPSON said some of Dr. Yarrow's remarks might be construed into a reflection on modern surgeons. The operation of which he speaks is one of the simplest which can be performed on the urethra. He himself had performed it four times within the last few months for various reasons. The patients were suffering from ruptured urethra, stricture, urinary infiltration, or some other trouble calling for this operation, which is nothing more than the median operation for stone. It is not the boutonnière operation devised and practised by Dolbeau. That surgeon, after an incision, used dilators for widening the membranous portion of the urethra. The operation as described by Dr. Yarrow, and as practised everywhere, cannot be a difficult one, for it would be almost impossible for the surgeon to miss the large groove of the staff previously introduced into the bladder. It is much more difficult to operate without the presence of a staff in the urethra.

DR. YARROW replied that he was quite well aware that Dolbeau had invented the boutonnière operation; but he also knew that Sir Henry Thompson had applied it to the removal of these tumors from the bladder. He had brought this case to the attention of the Society in order to show the ease with which papillomatous growths could be removed from the bladder.

DR. J. B. HAMILTON desired to call attention to several points in the case under discussion. It was of course necessary that a proper diagnosis be made. In order to distinguish between hæmorrhage from the kidney and hæmorrhage from the bladder, he would suggest the exhibition of gallic acid, which would stop the hæmorrhage from the kidney, but would have no effect upon the hæmorrhage caused by a papilloma. He had recently used this acid with good results in some cases of carcinoma uteri. In other situations as well as the bladder papillomata recur after removal. He had removed one from the cheek three times within a year—in January, May, and October last. They are also prone to take on epithelial transformations by reason of cell substitution. The mere removal of a papilloma from the bladder does not give assurance that it will not return.

As to the method of operation, the only philosophical way is to cut through the perineum. This operation is sometimes difficult and sometimes easy. Last summer he operated twice on account of impassable strictures. He operated without a guide. In one case he was twenty minutes, in the other an hour and fifteen minutes performing the operation. It is true there was a difference in the length of the strictures. So it might be with the attachments of the tumor. Generally, however, the operation is easy.

DR. THOMPSON said he had that day been consulted in reference to a case in a neighboring city. The tumor was described as being as large as a man's fist. He related the history of a case of papillomatous disease of the rectum in which he had operated as thoroughly as possible, but unfortunately the trouble has returned. He agreed with Dr. Hamilton that the disease frequently takes on a malignant character.

DR. YARROW could not see that the mere fact that the tumor might recur should prevent an operation. The man would certainly have died before this, and he is now more comfortable than he has been for fourteen years.

DR. A. F. A. KING was glad to know that surgeons were able to treat these troubles so easily and successfully. We must do the best we can for these patients, and give them the benefit of every chance. He wondered if there would not be less liability of a recurrence after an early operation following an early diagnosis. He thought there should be no difficulty in diagnosticating between hæmorrhage from the bladder and blood from the kidney.

DR. HAMILTON did not wish to be understood as speaking against the operation because the tumor may recur. If he had held such a belief he would not have operated three times on the case cited.

DR. REYBURN said that a diagnosis was easy soon after the tumor made some progress, from the fact that small pieces become detached and are voided with the urine. The amount of tenesmus caused by the presence of such a growth in the bladder is very great. He recalled some of the incidents of a case which he reported to the Society some time ago, in which the patient died after weeks of excruciating anguish. Whilst the operation is an old one, it is new in its application for the removal of papillomatous growths of the bladder.

DR. A. Y. P. GARNETT related the case of a female whose urethra he dilated for the purpose of applying styptics to a growth at the neck of the bladder. Two applications of nitric acid were successful. He thought it would be difficult to distinguish between the hæmorrhage caused by a villous thickening of the lining membrane of the bladder and hæmorrhage due to a papillomatous growth. But these villi do not offer such resistance to the contractile powers of the bladder, hence when they exist there is not such thickening of the vesical walls as where there is a papilloma present.

GYNECOLOGICAL SOCIETY OF BOSTON.

Stated Meeting, November 12, 1885.

THE PRESIDENT, H. O. MARCY, M.D., IN THE CHAIR.

DR. ERNEST W. CUSHING made some remarks on

THE RELATION OF BACTERIA TO CERTAIN PUERPERAL PROCESSES.

These observations were based upon the results of examination of the bodies of such women as died from these maladies in the General Hospital at Vi-

enna, last spring. He mentioned the great difference between the customs and rules governing the obstetric assistants and students in Berlin and Vienna. In Berlin every care is taken to avoid infection, either from foul hands or instruments or from the clothing or hair. In Vienna many of these precautions are omitted, and students are permitted to attend autopsies and operations on the same day. Obstetric operations and laparotomies are performed before the whole class, without spray, and the chief assistants give operative courses upon the cadaver every afternoon, relying for safety upon washing, bathing, and change of clothing. In spite of this seeming carelessness sepsis in puerperal cases is rare; this would seem to be an argument that puerperal septicæmia is not an entity that floats about in the air and enters the system through the lungs, etc., but that it is due to the development and propagation of bacteria introduced into the system directly from fingers, instruments or applications.

As a result of the examinations above mentioned Dr. Cushing stated that the most frequent cause of infection was the streptococcus; the next the staphylococcus, with which is frequently associated the bacillus pyogenis fœtidus. The streptococcus occurs in chains; the staphylococcus in bunches like grapes. One or other of the above species was found in every acute case, either in the iliac or uterine veins, or both. In pelvic abscesses they are found in the lungs and joints wherever metostatic abscesses are found. Microscopic preparations of the above were shown and specimen cases described.

In the discussion of Dr. Cushing's remarks the question arose in regard to the pathology of the chill which is so frequently noticed in pyæmia and other processes.

Dr. Z. B. Adams thought that in many cases the chill was not due to the presence of micro-organisms, but was simply a nervous manifestation due to nerve-irritation. The chill which follows catheterization was due simply to the irritation of the catheter carried to the nerve centres through the nerves alone. Rigors may occur from abscess when the abscess is separated from the surrounding tissues by impermeable walls.

Dr. Warner thought that chills are not always due to the presence of micrococci, but may be due to different causes in different cases.

Dr. Cushing maintained that catheter fever and the chills which precede or accompany catheterization are due to infection from foul instruments or catheters.

Dr. H. J. Harriman then read a paper on

HABITUAL CONSTIPATION IN WOMEN, ITS CAUSES AND EFFECTS.

(See page 150.)

Dr. Warner said that the condition of the bowels should be an important consideration in the treatment of all cases. Generally they will be found constipated, but careful attention to secure regular and full evacuations will often secure better results than any local treatment. Whatever success he had had in treating the diseases peculiar to women was due to constitutional rather than local treatment. Dr. Warner mentioned a case which he had once examined for pelvic trouble where he found the rectum greatly distended by fæces. The patient said that such could not be the case, as she had suffered from diarrhœa for several days. It proved that a canal had been formed through the fæcal mass through which the diarrhœal discharges had taken place. The speaker had used for years with great success the following pill in cases of habitual constipation: ℞. Pil. hydrarg., grs. iii; ext. hyoscy and ext. colocynth, aa, gr. i.

Dr. Wm. G. Wheeler mentioned the case of a school teacher who presented herself for treatment and stated that her bowels were regular. Treatment was carried out for some time without any improvement. More careful inquiry in regard to the state of the bowels revealed the fact that they "moved regularly once a month."

Dr. Marcy mentioned a case at Block Island in which thirty-one days passed without an evacuation of the bowels.

The President then read a communication from Dr. H. C. Ghent, of Belton, Texas, in which he called attention to a

NEW AND SUCCESSFUL AGENT IN THE TREATMENT OF VESICAL HÆMORRHAGE.

A patient was operated on for vesico-vaginal fistula. Wound healed by first intention. On fifth day after operation a furious hæmorrhage from the bladder occurred, and persisted for more than two days in spite of every effort for its control. The loss of blood was fearful. As a last resort equal parts of iced water and apple vinegar were injected into the bladder. Before a pint of the mixture had been injected the bleeding ceased and did not recur. Dr. Ghent raises the question as to whether vinegar or acetic acid has been before used for vesical hæmorrhage.

DOMESTIC CORRESPONDENCE

BRANCHES OF THE AMERICAN MEDICAL ASSOCIATION.

To the Editor of the Journal:

Dear Sir:—Some recent conversation on the subject of the formation of Branches of the American Medical Association, similar to those of the British Medical Association, has suggested the idea that some steps might be taken with this end in view at the coming meeting of our Association in St. Louis. That the formation of such Branches would be for the good of the profession generally, and therefore of the Association, cannot be questioned, unless we shut our eyes to the advantages derived from the system in Great Britain and her Colonies. The late Guéneau de Mussy said, a short time before his death, that the British Medical Association was the greatest medical organization in the world; and it is not difficult to see that its greatness is, in great part, due to its Branches.

It seems that the proper steps towards the formation of such Branches must be (1) some provision on

the part of the American Medical Association by which those who are already members of the Association may form themselves into separate bodies (Branches), which shall be so constituted, and have such powers and privileges, and be subject to such obligations, as shall be determined on by the Association in general meeting; (2) a provision by which societies composed of members and non-members of the Association may, upon application form themselves into Branches, under the same rules and regulations as stated in (1); (3) a provision empowering the Branches thus formed to admit members of the regular profession in good standing to membership in the Branches, and thus to membership in the Association.

It has been suggested that the making of a large Branch of a State Medical Society would scarcely be feasible, for two reasons: 1. The members of the State Society would object to being deprived of their liberty in this way, and being made a *dependency* instead of a sovereign society. Regarding this question there is much to be said on either side. The objects of the State Societies and of the National Association are the same: the promotion of medical and the allied sciences, and the maintenance of the honor and the interests of the medical profession. The State Society would still have control of its own members, and those members would also be members of the National Association. The ties uniting the State Societies (or Branches) to the American Medical Association would be similar to those uniting the States to the General Government. There can scarcely be a doubt that the profession in the different States will be brought more closely together, and in this way the medical men of the whole country; questions and methods of medical reform will be more easily settled and prosecuted; and altogether the advantages would outweigh the disadvantages.

2. A second question as to finances would come up when it was proposed to ask State Societies to become Branches of the American Medical Association. For example, the members of these Societies pay a certain sum each year as dues, part of which is for the publication of the Transactions of the annual meeting. It might be said that every member could not well afford to pay his dues in the State Society, and his Association dues in addition to this; and consequently, if the whole State Society becomes a part of the National Association the Association should secure to the members of the Society the publication of their Transactions. Two answers may be made to this: The number of members of a State Society who cannot pay the two sets of dues is extremely limited; so small that it may be practically eliminated. Again, the value of the average State Society Transactions, as printed, is very little, and the published Transactions could be easily and even profitably dispensed with in some cases. All sorts of papers, from good to very bad, are mixed in them. In some cases the time for papers is limited, as well as the space for any one paper in the published Transactions, and the papers often go out into the world half printed, and with some important discussion or conclusions omitted altogether. There is no good reason why the business proceedings of the Societies should not be published in the journal of the Association, and let the papers be published wherever the authors may elect. Such is the plan adopted by the Branches of the British Medical Association. It could scarcely be supposed that all the papers could be published in one journal.

In great Britain the dues to the Branches seem to be comparatively small; the dues for the Bath and Bristol Branch are only four shillings a year (less than a dollar). The regulations of the Branches of the British Medical Association seems to be very similar to those of our State Societies, with the addition that each Branch has a voice in the General Council of the Association, through its representative elected at the general meeting of the Branch. (Every Branch is entitled to elect one representative to the Council, and every Branch consisting of more than 200 members is entitled to elect an additional representative member for every complete 200 members of which it consists.) It may be remarked here that the General Council of the British Medical Association is for the purpose of taking a great deal of the business details out of the hands of the Association, and thus causing a great saving of time at the general meetings). The By-laws of the Association regarding Branches are as follows: 1. Any number of members, not being less than twenty, may form themselves into a Branch of the Association, subject to such Branch being recognised by the Council. 2. Each Branch shall be free to govern itself as its members shall see fit; but no Branch law shall be valid which, in the opinion of the Council, may contravene any fundamental law of the Association. 3. Each Branch shall pay its own expenses, and no Branch shall be deemed for any purpose the agent of the Association, or have power to incur any obligation in its behalf.

The Branches of the British Medical Association now number thirty-four, exclusive of Colonial Branches, representing a membership of about 7000 Branch members. (It should also be said that very many members of the Association do not belong to any Branch). Can there be any good reason why the American Medical Association should not soon become as powerful as our sister Association across the Atlantic? If there be any objections to the proposed system, would it not be well to put them forward now, in order that they may be avoided or met, as the case may be? Would it not be well for some of the members of the American Medical Association to discuss the subject in THE JOURNAL, so that some action may be taken at the next meeting of the Association, in St. Louis in May? Anyone who will take the trouble to look the matter up will be surprised to see the number of physicians in this country who do not belong to any medical organization at all. Even in some of the most populous States there are numbers of counties without any medical society; and in many of the counties in which medical societies exist, there are numbers of medical men who have no connection with them. If the plan suggested in this communication should be carried out, there seems to be no reason why nine-tenths of our physicians should not belong to a BRANCH.

MUTUAL PROTECTION AGAINST BLACKMAIL.

To the Editor of the Journal:

Dear Sir:—I have read with much interest the various expressions of opinion concerning the subject of protection against blackmail, published in The Journal of January 30. In considering such a question as this it is useless to rail at "shysters," or to assume that every action for malpractice is a case of attempted blackmail. So far as my observation extends, the average lawyer is no better, and certainly no worse than the average doctor; and so long as human nature is unchanged I suppose that there will be both shysters and quacks. Without doubt many cases of malpractice exist which never find their way into court. I do not think that any respectable lawyer would bring a case which he thought groundless; but I am quite certain that many medical men of apparently good standing in their profession are open to the criticism so well expressed by Dr. Hotz in the discussion of Dr. Doering's paper.

In my opinion, much more can be done in the way of preventing suits than has been attempted. This may be accomplished in several ways: (a) by reputable physicians refusing to countenance such suits by abstaining from criticism, and by being a little more cautious in giving so-called expert testimony; (b) by taking some pains to learn what their rights and duties are; and (c) by paying more attention to the preservation of evidence in all cases in which there is a possibility of a question of malpractice being raised.

As to the association discussed in your columns, the matter deserves serious consideration. While there is no doubt that membership in such an association ought not to affect the decision of the issue in a malpractice case, still there is no doubt whatever that on cross-examination the fact of such membership would be made to appear. To foretell the effect of such a fact upon the average jury would require omniscience. It ought not to prejudice them, provided the association appear to be for the purpose of protection against vexatious and groundless actions, and provided it be made distinctly to appear that every case is impartially investigated, and the prosecution of well-grounded actions encouraged instead of discouraged. As to any attempt by such an association to prevent physicians from testifying in proper cases, even to the extent of disclosing professional secrets, I have no doubt whatever that, in the present state of the law, which needs amendment in this respect, such attempt would be unlawful.

It is worthy of consideration, however, whether such an association might not discourage champertous contracts between attorneys and blackmailers; in other words, discourage taking cases on "spec," to use the words of the worthy Samuel Weller in the famous case of Bardell vs. Pickwick, by instituting prosecutions for champerty against attorneys guilty of such practices; for there is no doubt whatever that taking such cases on shares is to-day a criminal offense in this State.

Some twenty years' experience in the study and practice of the law and several years' study of the subject of legal medicine lead me to think that many of the groundless suits would be shorn of many of their terrors were the defense more efficiently conducted. Most lawyers are as ignorant of medicine as most doctors are of the law, and that is saying a great deal. In a case in which I was interested a year or so ago, the counsel for the plaintiff, a well-known trial lawyer, betrayed the most colossal ignorance of the affection in question. To retain an attorney and expect to teach him the science of medicine and surgery by defending malpractice suits, as suggested by one of the correspondents, would be rather a perilous undertaking for the unfortunate defendants who happen to furnish the first series of cases—I had almost said cadavers. That the attorneys do as well as they do, however, is a high compliment to the profession; but to expect that a non-medical man can be able to "cram up" on a case so as to understand the subject in all its relations, in the short time at his command, is expecting too much; they must be supplemented by the doctors themselves, or must be medical men. It is manifestly impossible and highly dangerous to a cause to examine or cross-examine a witness upon a topic with which the examiner is not well acquainted.

I do not think that lawyers and doctors cultivate the acquaintance of one another so much as their interests require. A medico-legal society would be useful in this respect, but I doubt whether it could be maintained in this busy city, where the race for wealth absorbs so much attention. In Continental Europe and Scotland the practice of legal medicine is rightly made a specialty. If the members of the medical profession in this city would afford suitable facilities for attendance upon autopsies, etc., to such persons as feel inclined to cultivate this department, I doubt not persons could be found, both honest and capable, who would specialize in this direction. At present I believe that New York is the only city in this country in which anything has been done in this direction, and I do not know to what extent such efforts there have proved successful. Again, I think that our medical schools should pay more attention to the subject of medical jurisprudence. So far as my observation extends very few physicians are well informed upon this important subject, and I think the fault lies with the medical colleges. The subject should form a part of the course of every law and medical school, and should be taught by one who is sufficiently well informed to give the students such practical information as will enable them to know their rights and duties in advance of a suit for malpractice. The doctor who studies medical jurisprudence for the first time as a defendant in a malpractice suit, or when cross-examined in open court, is not most felicitously situated either for giving or receiving instruction. In conclusion, permit me to suggest that a special meeting of reputable physicians be called for the discussion of this subject. A comparison of views by word of mouth will accomplish more in one evening than can be done by a year's writing.

I am, respectfully,

Marshall D. Ewell, M.D.,
170 Washington St., Chicago, February 2, 1886.

COCAINE; WHAT WAS ITS INFLUENCE IN THE FOLLOWING CASE?

TO THE EDITOR OF THE JOURNAL:

Dear Sir.—With the view of increasing the amount of clinical evidence as to the value and effects of cocaine, I submit the following history of a case treated in the Missouri State Lunatic Asylum No. 2:

Esther C., admitted October 21, 1884; aged 39 years, married 20 years, mother of four children, youngest 2½ years old. She was a strong, healthy woman until four years after marriage, about which time she became affected with some uterine trouble, and was never strong and well afterwards. She had never any acute serious illness. Eighteen months previous to admission the first symptoms of mental derangement were observed, manifested by neglect of maternal and household duties, and by frequent attempts to leave home alone, by day and night. She became despondent and melancholy, feared injury and death, destroyed her clothing and the furniture, did not eat or sleep much, had periodical attacks of excitement and violence, and threatened to kill herself and baby. She had delusions in regard to religion. There was no insane heredity, but her mother was an exceedingly nervous woman. Her expression was anxious and distressed, and she was restless and discontented.

The thoracic and abdominal organs were sound, and performed their functions very well. Cervical and corporeal endometritis existed, associated with profuse vaginal leucorrhœa. She was greatly depressed and profoundly melancholic, constantly lamenting and complaining that she was the most miserable of beings, and expressing a desire to change her surroundings where sympathy could not reach so unworthy and wretched an object. She was removed from the Asylum by her husband in June, 1885, having remained under treatment for six months. She was greatly improved, both in physical and mental condition, when removed.

In September, three months after her removal, she was re-admitted in a much more deplorable melancholic state than when first she came under observation. She had attempted suicide, and was completely inconsolable. Her physical condition was low, the uterine disorder and leucorrhœa had re-appeared, and her second state was altogether worse than the first. On November 2 the use of hypodermic injections of hydrochlorate of cocaine was commenced, Dr. A. P. Busey administering one grain at 9 A.M., and the same quantity at 4 P.M. This was continued for thirteen successive days. At this period her physical condition had improved, she was stronger and better nourished, her appetite was better, and she slept better; but her melancholy was as profound and her lamentations as distressing as usual. At this time there appeared several irritable boils upon the face, scalp and neck, which was the only indication of systemic disorder.

The cocaine had a pleasant effect upon her, always acting as a cerebral and nervous stimulant, and it exhilarated and enlivened her for from one-half to one hour after the administration. She was so pleased with its effects as to request its administration with great earnestness. It always increased the pulsations of the heart from twenty to twenty-five beats, and the sphygmograph uniformly indicated very considerable increase of arterial tension. It did not produce nausea or loss of appetite, nor did it produce uniformly marked paleness of the surface, which is one of its chief primary characteristic effects. Nothing indicating illness was noted at the time when the last evening portion was injected, but during the night she complained of pain in her head, especially on the left side, and she became restless and sleepless. On the following morning the temperature rapidly increased, and the pulse also increased in frequency and force, indicating serious constitutional disturbance. The surface of the extremities was pale and cool. The face was discolored, bluish, turgid and puffed. The eyeballs were perceptibly swollen, the eyes dull, pupils motionless, and the vessels of the ball filled with blood. The left side of face was more discolored than the right. There was a continuation of the severe pain in the head, and articulation and vision were perceptibly impaired. She could not be aroused to give an intelligent reply to questions. Delirium soon supervened. The discoloration and swelling of the face continued. The circulation of the extremities diminished. The balls of the eyes rapidly protruded, and within a few hours they had protruded so far that the lids could not cover them. The balls felt hard, dense and resisting. Violent delirium passed into profound coma, which terminated fatally within thirty hours from the time the last injection was given. Unfortunately, no autopsy could be obtained.

The importance of this subject requires no apology for giving minute details of the case. The following conclusions have been arrived at from the observed effects of cocaine, which has been administered very extensively to the insane within the past five or six months:

1. It is an agent possessed of great potency. It acts primarily with great power and celerity upon the cerebral and spinal nervous system, and secondarily upon the heart and vascular system.

2. From its potency and rapidity of action it is liable to initiate organic lesions and functional disturbances which are uncontrollable. It is not uniform in its action, and therefore is an uncertain agent.

3. Its effects are too transient and unstable to become a reliable and efficient remedy in constitutional or organic diseases. The aphrodisiac effects attributed to it have not been observed, neither have the intense nausea and inability to vomit been observed. Its permanent beneficial effects in melancholia and allied affections are not established facts, in the writer's opinion.

4. As it is an agent of great potency, and as it is under trial to determine its limits of usefulness and danger, it should be prescribed with increasing precaution and discretion.

GEO. C. CATLETT, M.D.,
Physician and Superintendent of State Lunatic Asylum.

St. Joseph, Mo., January 30, 1886.

BOOK REVIEWS.

VORLESUNGEN ÜBER BACTERIEN, VON A. DE BARY, Professor an der Universität Strassburg. Mit 18 Figuren in Holzschnitt. 8vo, pp. vi, 146. Leipzig: Verlag von Wilhelm Engelmann. 1885.

BACTERIA. By A. DE BARY, Professor in the University of Strassburg. Leipzig: Wilhelm Engelmann. Chicago: Koelling, Klappenbach & Kenkel.

Professor de Bary is well known to bacteriologists and biologists by the three works from his pen which have already been published: "Die Fruchtentwickelung der Ascomyceten," in 1863; "Die Mycetozoen," in 1864; and his greatest work, "Vergleichende Morphologie und Biologie der Pilze, Mycetozoen und Bacterien," 1884. The purpose of the little work now under consideration is to give an insight into the nature of bacteria, but the author states in his preface that one must not expect to find a complete treatise on bacteriology.

The first six chapters, covering fifty pages, are devoted to the biological and histological study of bacteria in general. Then comes a chapter relating chiefly to the subject of fermentation; chapter VIII is devoted to the Saprophytes. The subject of fermentation is again taken up in the next chapter. The remaining chapters deal with the parasitic bacteria, including a general discussion of parasitismus. The harmless bacteria of warm-blooded animals are discussed in a short chapter, *Milzbrand* and Chicken-cholera in one of eighteen pages, and the "Causative Relations of Parasitic Bacteria to the Infectious Diseases of Warm-blooded Animals" in one of twenty pages. The last chapter concerns the "Bacterial Diseases of the Lower Animals and of Plants."

It will be seen by this short account of the scope of the work, that methods and questions of cultivation of bacteria receive but very little attention. Nevertheless, the work contains a vast amount of interesting reading and positively useful material—material that cannot be obtained in such concise form in any other work of which we have any knowledge. It is completed by a good index.

PRACTICAL SURGERY: INCLUDING SURGICAL DRESSINGS, BANDAGING, FRACTURES, DISLOCATIONS, LIGATION OF ARTERIES, AMPUTATIONS AND EXCISION OF BONES AND JOINTS. By J. EWING MEARS, M.D., Lecturer on Practical Surgery and Demonstrator of Surgery in Jefferson Medical College, Surgeon to St, Mary'sHospital, etc. With 490 Illustrations. 8vo, pp. xii, 794. Philadelphia: P. Blakiston, Son & Co. 1886. Chicago: W. T. Keener.

As a convenient work on practical surgery, this, the second edition, is much in advance of the first. Three new sections—on fractures, dislocations, and resections—have been added, and enhance the value of the book, and the section on antiseptic dressings has, of course, been almost entirely rewritten and much improved. Indeed, it is not sufficient to say that it has been much improved, since it is now a very clear and concise statement of the antiseptic methods of surgery.

Of the chapters devoted exclusively to surgical technics, the one on excisions is perhaps the most pleasing, and of this chapter the part on excisions of the face. This is only natural, in view of the fact that the author has won an especially enviable reputation in this particular field of surgery. Though there may be a few points on which many surgeons would differ from the author, as a whole the work is excellent; the student or practitioner who follows it intelligently cannot easily go astray. We could wish that a chapter had been added on operations on the abdominal and pelvic cavities, and on the operations for hernia.

ASSOCIATION ITEMS.

INFORMATION OF IMPORTANCE TO ALL MEMBERS OF THE PROFESSION IN AMERICA.

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MEMBERSHIP.—Every one who attends an annual meeting of the Association as a delegate pays at that time five dollars, and thenceforward becomes a Permanent Member. He continues as such as long as he remains in good standing in the body from which he was originally sent as a delegate. As a Permanent Member, he must pay *Five Dollars Annually*, when notified by the Treasurer, whether he attends the meetings of the Association or not. Payment of annual dues entitles him to receive the weekly JOURNAL of the Association for one year.

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SUBSCRIPTIONS TO THE JOURNAL, from those who are not members of the Association, should be forwarded to the office of publication, 65 Randolph

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RICHARD J. DUNGLISON, M.D., *Treasurer.*
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MISCELLANEOUS.

MIRYACHIT.—In an editorial note on this subject the *British Medical Journal* says: Etymologically the term *miryachit* is decidedly a failure, originating from a defective knowledge of Russian. *Miryachit*, or, as it should be written, *miriatchit*, means literally "he or she fools," or "plays the fool." It is derived from the verb *miriatchitje.* The verbal noun is *miriatchenïe* (fooling or playing the fool); he or she who *miriatchit*, is *miriasha.* Hence—if it be desirable to retain a Russian word—it would be more sensible to call the disease *miriatchenïe*, as it is called in Russian, instead of *miryachit* (he fools). In the *Vratch*, No. 36, 1885, p. 602, Dr. Jankovsky publishes an interesting note on an epidemic of this curious neurosis, which has come under his observation in the Littoral District of Eastern Siberia. He first came to be acquainted with *miriashas* in this way. One fine evening in 1876, shortly after he had been appointed surgeon to the 1st Eastern Siberian Infantry Battalion, a *feldsher* (assistant-surgeon) on duty hurried to him with a startling information that fourteen "mad" soldiers had been brought to the hospital. On his arrival, the author really found a crowd of the patients, and, naturally enough, addressed to them the question, "What is the matter with you?" To his greatest astonishment, all fourteen addressed him in chorus, "What is the matter with you?" He tried then to put the interrogation in another way, "What ails you?" The answer followed again, "What ails you?" In short, every word of the medical man was simply echoed by every one and all of the patients. On examination, he found, in every individual case, increased apex-beat, rapid pulse, extreme nobility of the limbs, (especially of the hand), somewhat increased cutaneous sensibility, dilatation or contraction of the pupils, gay disposition, laughter, or smiling, without any reason whatever, etc. While the author was examining the patients, an officer in command arrived, and informed him that all the men had had for their supper potatoes with hemp-oil, the latter being bought of a Corean hawker. On hearing the work "oil" (*maslo*) spoken by their commander, all the soldiers suddenly went on with repeating "Oil, oil, oil," in all possible manners, in spite of all entreaties and injunctions. In view of the fact that one of the patients vomited, and after vomiting ceased to "fool," the author ordered emetics and purgatives in every case. The patient, slept quietly through the night, and on the next morning all were well, being able to only vaguely recollect the events of the previous day ("as if in a dream"). An inquiry elucidated that the Corean oil-merchant was a *miriasha*, and that "fooling" attacked only those soldiers who had seen and spoken to him. Another case of multiple *miriatchenïe* was observed by Dr. Jankovsky in Vladivostok in 1878, in four children of one family, aged from 3 to 7 years. Sporadic cases of "fooling" were met with by him very often. As a rule, the disease is chronic, and apt to spontaneous remissions. It begins mostly under the influence of contact with a *miriasha*, but sometimes is hereditary. It attacks only natives and "well acclimatised" immigrants, and here again only children and subjects of a "low intellectual level." The general health of the *miriasha* remains intact. The disease usually does not interfere with the occupation of the patient. It is obviously a form of "epidemic male hysteria."

PROGRESS OF SMALL-POX AND CHOLERA.—From the circular of the National Board of Health, dated January 27, 1886, we take the following results of small-pox in Montreal up to January 20, 1886. During the week ending Jan. 21 there were 10 deaths in the city and 6 in its suburbs. The total number of deaths from small-pox in the city of Montreal from the beginning of the epidemic in April to December 31, was 3,164, as follows: In April, 6; May, 10; June, 14; July, 46; August, 239; September, 659; October, 1,393; November, 633; December, 165. There were also 363 deaths from measles, typhoid fever and diphtheria during the year, and the total mortality from all causes during 1885 was 7,885 as against 4,358 during 1884. Consular reports from different parts of Europe show that the disease is decidedly declining as a whole.

From the same sources we learn of the continued prevalence of cholera moderately in the Province of Huelva in Spain, and in the single Department of Finisterre in France.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM JANUARY 23, 1886, TO JANUARY 29, 1886.

Col. John E. Summers, Surgeon U. S. Army, retired from active service, by operation of law, Jan. 24, 1886. (S. O. 20, A. G. O., Jan. 25, 1886.)

Major Wm. E. Waters, Surgeon, granted leave of absence for one month and fifteen days. (S. O. 5, Div. Atlantic, Jan. 23, 1886.

Asst. Surgeon J. M. Banister, ordered for temporary duty at Ft. Warren, Mass. (S. O. 16, Dept. East, Jan 23, 1886.)